Content and Psychology

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Chapter 1: Introduction to *Content and Psychology*

Introduction: The Defense of Narrow Intentional Psychology

In this dissertation, I will be discussing and defending ***narrow individual intentional psychology*** (or, as I'll sometimes be calling it, *notional world psychology*), an actual instance of the type of flourishing theoretical and practical discipline that has been called a *paradigm* since Kuhn (1962). Since these are all terms of art, I'll start by just briefly indicating what I mean by them, using what philosophers like to call recursive definitions (relating them to yet further undefined terms, in the hope that together their sense will become more clear), working from the outside in.

Psychology is a valuable and important discipline, both in theories and applications, which is dedicated to uncovering the principles and mechanisms underlying behavior, with the aim of improving the quality of our lives by helping us to learn to deal with our environment and each other more effectively. At least, that's the definition we'll be working with here.

Intentional psychology is familiar to us all. Focussing mainly at the level of the individual's *actions* (such as running away from someone, or strangling them[1]), it is the theory and practice of accounting for *meaningful* or *purposive* behavior by invoking the existence of underlying mental events of the type philosophers call *the propositional attitudes*. These *states of mind*, such as *beliefs*, *desires*, *intentions*, *hopes*, *wishes*, *dreams*, *fears*, *expectations*, and hosts of others, are thought to be responsible for actually ***producing***[2] the behavior or symptom in question. These attitudes, moreover, have the somewhat peculiar characteristic that phenomenological psychologists such as Brentano (1960) and philosophers such as Searle (1983) call ***Intentionality***: they are all *about* or *of* something – they have *content*, *significance*, or *meaning*, or, as Dennett (1982) puts it, we can "***make sense of***" them. As we'll see, clinicians applying this theory have discovered that the act of making sense of someone's behavior by interpreting the content of experiences and states of mind responsible for producing it can be extremely beneficial when that understanding is imparted to them.

Individual psychology attempts to understand and change the behavior of individuals, unlike, say, *social* psychology, which studies groups. Although individual psychology encompasses areas such as developmental psychology, we will be focussing mainly upon the discipline known as *clinical* psychology.

The ***narrow*** part designated the methodological precept of the practice that the psychologically relevant properties causing behavior reside entirely within the agent. Put crudely, the operative assumption is that a person's feelings and ideas are 'all in his (or her) head,' as is the meaning of his actions, since that's where our actions are caused.

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[1] Thus, for readers who would like a gripping instance of a propositional attitude explanation, consider, "Othello strangled Desdemona because he thought she'd been unfaithful to him."

[2] As we shall see, "production" is an appropriate term here, since it connotes a structural, causative process, suggests an agency of a purposive, even theatrical type, and it alludes to computational production systems.

The notion of "***notional world***" psychology, a philosophical way of characterizing narrow intentional psychology, was put forward by Dennett (1982). As we'll see, it has close connections with the phenomenological tradition of Edmund Husserl and it nestles comfortably with the theoretical model implicit in most psychotherapy.

Finally, whether it is to be called "folk" psychology, "narrow" intentional psychology, or "clinical" psychology,[3] it will become clear that we are dealing here with a genuine ***paradigm*** in the (main[4]) Kuhnian sense, which I'll operationalize here as, "A professional and accredited alliance of researchers, educators, and practitioners applying theories to understand and control some phenomena." In one of its guises, this particular paradigm, intentional psychology, is known as "Clinical Psychology," and it is a discipline that trains and employs many (but not nearly enough) thousands of practitioners and researchers who attempt to understand people's behavior in intentional terms and to apply that understanding to help us change our lives for the better.

That, then, is the area I'll be defending; now let me tell you briefly why. Despite (or perhaps because of) the fact that it is a flourishing paradigm with extensive applications, this type of psychology has long been the target of attacks by academics and professionals of many rival persuasions: medical, psychological (i.e., behavioral), and philosophical. Impelled as I am by the convictions that its services are desperately needed and that its theories aren't nearly so shabby as some contend, and by the sentiment that I'd hate to see it or any other vital social service put out of business by sniping critics, I resolved to contribute to its defense. In a single dissertation, however, I would be unable to adequately fend off all the criticisms confronting it, so I had to narrow them down to the ones I thought were the most serious challenges that I might be able to help intentional psychology answer.

At the inception of this project, I was going to address the notorious "mind/body" problem and provide a primarily philosophical defense of the intentional paradigm to answer the challenge, "How is it possible for *physical* systems to have *mental* states, which have the property of being *about* something?" (Or, more polemically: How could any self-respecting scientist think that "folk" attributions of "ideas" and "feelings" belong in credible, genuinely scientific explanations?) I planned to show that, despite the professional divisions among them, there is actually quite a rapprochement to be found between the adjacent disciplines of philosophy, psychology, and cognitive science; I was to explain how some of the "intentional" properties that are talked about in phenomenological theories and that are attributed to people in common sense psychological explanations can actually be grounded in respectable computational and neurological models.

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[3] I'll be supporting this implicit claim that folk psychology employs a "narrow" psychological model in clinical applications as we go, especially in Chapters Four and Five.

[4] In Kuhn (1962), paradigms have to do with both theories and practices. However, I don't intend to imply that these are the only senses to "paradigm" in Kuhn's writings; by some counts, there are at least twenty-one in Kuhn (1962) alone: see Margaret Masterman, "The Nature of a Paradigm," in Lakatos and Musgrave (1970, pp. 61 ff.). I'll be arguing that notional world psychology is a paradigm in the sense that it is a professionally accredited alliance of researchers, educators, and practitioners which develops and applies theories to understand and control some phenomena.

Some day, I may even return to that project, which would discuss "schema theory," "intrinsic intentionality," "emergent properties," and "brain-in-the-vats" extensively. In the meantime, however, responding to the complaints of the philosophical "anti-realists" who don't see how thinking could simply be a matter of complex brain processing has seemed less of a pressing concern, since I have been surrounded by "eliminativists" (whom I shall introduce momentarily) and other brain scientists who are advocating or forecasting the demise of intentional psychology, and so I came to feel that my services were needed elsewhere. Consequently, my research has taken a decidedly more pragmatic turn, for I shall be defending intentional psychology on the basis that its services are vitally needed and are to be preferred over those advocated by its critics, ***whether or not*** we are comfortable with its ontology.

But since a defense would be boring or pointless without the threat of an attack, let me now introduce the main opposition, who also tend to be impatient with purely philosophical objections and want to criticize and evaluate the fate of paradigms on pragmatic grounds. While some of the parties to the dispute will be philosophers looking on – primarily the "eliminative materialists," Stephen Stich and Paul and Patricia Churchland,[5] whose views will be discussed extensively in what follows – others will be rival professionals, be they "*pharmacotherapists*" (or drug- doctors and -companies) or "*behavioral*" therapists (such as Hans J. Eysenck). As we shall see, these critics are at least forecasting this particular "helping profession" (as fields such as it and social work are called) will eventually be disenfranchised from the scientific community, if not actively calling for its speedy removal. Stich (1982, p. 204) for example, articulates the "darker suspicions" of the eliminative materialists, who "fear that the notion of a contentful belief or memory, borrowed from folk psychology, may be singularly unsuited to the purposes of scientific psychology;" while their "conviction" is expressed by P.M. Churchland (1988, p. 45): "folk psychology is a hopelessly primitive and deeply confused conception of our internal activities."

Normally, such criticism of a paradigm in its apparent prime of life tends to be either harmless, because of its prematurity, or stimulating and beneficial, through its challenge to complacency. However, because the sometimes quite vocal challenge of eliminativism is presented not in the spirit of some far-off and remote academic possibility, but as a pragmatic issue to be grounded in actual practice and current policy-making, and because this is a field that is desperately needed (as I shall be arguing below), and because such adverse criticism can influence those who are in charge of the distribution of education and health care resources to deprive it of the institutional support and funds that are needed for it to continue to be of help,[6] it is appropriate to examine the

[5] I don't mean to imply, however, that these three individuals are the only eliminative materialists. Other spokesmen who became "radicals" in the philosophical community by sometimes inadvertently representing the interests of established science, medicine, and pharmaceutical companies are: Richard Rorty (see his 1970, "In Defense of Eliminative Materialism," reprinted in Rosenthal (1971), and Rorty 1979); and W. V. O. Quine (1960), who helped Behaviorism along with passages like this: "One may accept the Brentano thesis either as showing the indispensability of intentional idioms and the importance of an autonomous science of intention, or as showing the baselessness of intentional idioms and the emptiness of a science of intention. My attitude, unlike Brentano's, is the second. (Quine 1960, p. 221, quoted in Dennett 1982, pp. 93-94)" I will, however, be confining myself to the criticism of only the eliminativists mentioned in the text, whose views are to be found in Stich (1983, 1984); P.M. Churchland (1981, 1988); and P.S. Churchland (1986).

[6] Philosophers need to acknowledge that their discussions are embedded within and are relevant to issues that are being played out in a wider forum. There is in fact an intense de facto competition for resources between psychotherapy and medical psychiatry. For example, as the August 1979, *Psychiatric News* (the newspaper of the American Psychiatric

substance of both the charges that have been made against intentional psychology and the claims that have made in favor of the proposed alternative paradigms. Accordingly, that's just what I propose to do, and what follows will be my report.

Grand Overview

The dissertation will defend narrow intentional psychology from certain philosophical challenges, and examine the clash between the content-based paradigm of intentional psychology and its chief rival, medical psychiatry, and a further candidate, the Syntactic Theory of the Mind (STM), to be described below. It is divided into three main parts, the thrust of which I'll describe here briefly.

Part I divides into three chapters: a somewhat selective historical overview of the fields of philosophy of language, psychology, and mind, in order to explain the foundation of the challenge made by the "wide" theorists to be discussed; followed by a chapter which explains why it is at least ***possible*** for there to be a narrow intentional psychology; and, finally, a chapter explaining why it ***desirable*** for there to be such a discipline. This will lead us directly to Parts II and III, which not only continue to elaborate on the importance of keeping such a discipline in good working order, but also describe in detail the ***actual*** clinical practice of narrow intentional psychology, comparing and contrasting that to what the competing paradigms can do for and to us. The latter parts each have two extensive chapters, bringing the total to seven.

Brief Overview of Part I

Written initially for philosophers, as it still is, Part I begins with an overview of the developments in the philosophy of language which led up to the challenges of the first two Parts. After introducing the issues, it will respond to criticisms of Saul Kripke (1980), Hilary Putnam (1975, 1983), and Tyler Burge (1979, 1986), who maintain that "meaning isn't in the head," and advocate what I'll be calling "wide" philosophy of language. Burge (1986) also goes on to contend on that basis that my favored paradigm, "narrow" intentional psychology, doesn't even exist, nor can it, given their collective views on the social and environmental contributions to our language and thought, and the way people go about the business of ascribing content to one another's propositional attitudes.

Since I have claimed that narrow psychology is needed and I'll later be arguing that it is alive and can be conducted well, the logical first step to meeting this challenge that it can't be done is to show why it is both desirable ***and*** possible for there to be a practice which proceeds on the assumption that people have wholly internal representations, whose practitioners not only attempt to understand and report on the content of these representations, but also to modify it by changing the way we look at the world and ourselves. Accordingly, I shall discuss the reasons why clinical psychology, at least, does and should employ a narrow model of the meaning of propositional attitudes, despite the observations about the public nature of our language and the intuitions about content ascription and the importance of reference put forward by these

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Association) put it, after reporting on the testimonies of psychiatrists and psychologists before the Health Subcommittee of the House of Representatives on proposed Medicare amendments: "A psychiatrist-psychologist turf war is indeed raging on the floor of the House." (Reprinted in Dongier and Wittkower 1981, p. 49.)

philosophers, many of which, I shall be arguing, pertain to the field of sociolinguistics rather than to clinical psychology.

Brief Overview of Part Two

Part II deals with another philosopher, Stephen Stich, who exploits some of the intuitions of the "wide" philosophers and draws upon formal and linguistic models and the research paradigm of cognitive science known as "computational psychology" to propose an alternative but "narrow" paradigm of his own: the "Syntactic Theory of the Mind" (STM). In Stich's view, the practice of psychology has no need of the alleged content of the propositional attitudes, and we can get by with a purely formal approach that eschews the interpretation of *what* we may be thinking or feeling. In fact, he charges, we would be better off doing so, since interpretive approaches are far too "parochial" or limited in scope, at least as compared to his syntactic (or quasi-grammatical) approach. Since interpretation is, as one might say, the very heart and soul of what intentional psychology is all about, Stich's implicit challenge is thus either that we don't need clinical psychologists, or that clinical psychology needn't be intentional psychology and mental health practitioners don't have to bother to really try to understand others' mental states in order to help them. Each of these claims is false, in my view, and I shall explain why in Chapter 5, which details the serious practical limitations of STM and related behavioral methods of control, and Chapter 6, which explains the importance of content in clinical psychology and responds to objections about the limitations inherent in the method of narrow content ascription and understanding.

Brief Overview of Part Three

Part III takes on yet another set of philosophical opponents, the Churchlands, Patricia and Paul. As self-styled "eliminative materialists," their concern isn't so much with whether intentional or propositional attitude psychology needs to be narrow or wide; they have bigger fish to fry, as they openly challenge whether it is needed at all.

In their view, there will soon (maybe not today or tomorrow, but *soon* – or else this just is an academic debate, in the pejorative sense, which is not what they intend it to be) come a time when the professional services of intentional psychology simply won't be needed any more, as it will be edged out by a vastly superior scientific paradigm which has a deeper understanding of and a greater facility to change the phenomena being addressed (ourselves). As we shall see, the Churchlands aren't just offering an idle speculation that some day something better may come along, for they are actively backing psychology's current competition, neurobiology, together with its attendant practices of psychopharmacology and neuropsychiatry.

Thus, rather than simply expressing possibly mistaken views about the nature or methods of clinical psychology, the "neuro-eliminativists" are not only predicting its demise, but they are also furthering the interests of its main rival, medical psychiatry, in the often acute competition for resources and legitimization. Consequently, of the philosophical opponents to narrow intentional psychology, they are a most formidable threat, since they advocate means of mental health intervention that have the very real potential to cause serious harm, as we shall see, so their challenges warrant the most extended reply.

Accordingly, in the lengthy final Chapters, I shall explain why we now need intentional psychology even for the treatment of the so-called mental illnesses (where the contrast between the approaches is the most acute), and why we are quite likely to at least for the foreseeable future. These Chapters will elucidate and extol the strengths of psychotherapy even in the treatment of psychoses, the toughest cases in its domain; elaborate on the serious limitations and adverse effects of alternative means of control; discuss the reasons why these methods have received such wide support despite their limitations; and finally, make some suggestions for improving the delivery of mental health care services based upon these findings.

Obviously, there will be a lot of territory to cover in this excursion into philosophy of language, clinical psychology, and medical psychiatry, so the dissertation will be quite lengthy. Given the enormity of the problem, however, I can only ask the reader's forbearance, since the matter of whether we need the services of a multi-billion dollar industry to treat millions of miserable people is of some considerable urgency in our deficit- and trouble-ridden society. In the interests of brevity, I have, however, consigned many somewhat tangential issues to the Appendices.

With that much said by way of introduction and ***Apology*** for the proceeding, just so you'll have a better sense of where you'll be going, I'll now give a slightly more detailed opening gloss on the content of each of the three ensuing contests, and a brief summary of each of their chapters, before immersing you in the details.

Kernel of the Argument for Parts I to III

As mentioned, the dissertation is divided into three main parts; I shall briefly sketch the thrust of their contents here.

The development of Part I is as follows. First, I provide a brief overview of the fields of philosophy of language, philosophy of psychology, and philosophy of mind in this century to set out the foundations of both the narrow intentional program I'll be defending, and the challenges to it presented by the "wide" philosophers Hilary Putnam and Tyler Burge. Next, I will explain why it is at least ***possible*** to practice narrow intentional psychology, and then I'll go on to describe parts of the problem domain confronting applied intentional psychology to show why it is ***desirable*** to have such a discipline. Although aspects of it will be wide, such as its explanatory "frame" (which includes an 'objective' characterization of the subject's behavior, and a diagnosis or evaluation of their state of mind), I'll be explaining why the ***content*** of the intentional explanations of individual psychology should be narrow if they are to be fully serviceable, given the considerable numbers of people who diverge from the views of the "experts" and the "norm." Finally, I'll describe in some detail the ***actual*** clinical practice of narrow intentional psychology, as carried out by those psychotherapists who subscribe to "notional world" or phenomenological models and who go beyond conventional interpretation to use empathic or projective understanding to ascribe content.

Having explained why it is appropriate for clinical psychology, at least, to adopt a ***narrow*** point of view in the two Chapters of Part I, Parts II and III will continue to elaborate upon the

importance of keeping notional world psychology in good working order by emphasizing the importance of pursuing an ***intentional*** approach to psychological problems, in response to the challenges of the eliminative materialists, who advocate paradigms that would attempt to avoid using intentional theories and methods altogether. Taken at their word, it would seem that eliminativist therapies eschew folk psychological methods such as using empathy or projective understanding to ascribe and interpret the intentional content of people's psychological states, and then using reasoning and persuasion to alter these attitudes. Instead, they rely on alternative and usually more direct means, such as behavior modification techniques, or drugs. We shall be examining these and similar approaches in Parts II and III, comparing and contrasting their therapeutic effects and side-effects to those of intentional psychology; but before considering those contests severally, let me sketch the form my overall defense of the intentional paradigm will take in them both.

Quite simply, my strategy for defending intentional psychology is to examine whether some of its most important duties could be satisfactorily performed by its eliminativist competitors, and to argue on the basis of that investigation that, because it is probably not the case that content-based methods and therapies could be reasonably or beneficially eliminated, eliminative materialism is wrong. As I'll explain in more detail below, this seems to be a fitting way to proceed. After all, if a discipline's services are both irreplaceable and needed, then the likelihood that we will rid ourselves of it completely is slim indeed (although we come much closer to it during some Administrations), and thus the eliminativists' ***prediction*** would seem to be quite false, and any ***prescription*** they may be making to the effect that we should withdraw aid to intentional psychology and put all our trust in neuroscience or formal cognitive science would seem to be very bad advice indeed. My basic argument against eliminative materialism is thus quite simple:

(1) we need some sort of therapy for our psychological problems;

(2) psychotherapy is *prima facie* the most appropriate mode of treatment for these problems, since they ***are*** (or at least seem to be) psychological problems which respond to understanding;

(3) psychotherapy employs content, projective understanding, and the constructs of folk psychology such as belief and memory; therefore,

(4) folk psychology and content ***are*** suited to the needs of psychology, and (unless something drastic happens to us) probably always will be.

However, since the conclusion that folk psychology is needed would be undermined if alternative therapies could do just as well or better, I shall also be arguing (5):

(5) viable alternatives to content-based therapy are either non-existent or inadequate, or their effects are worse.

That, then, is the structure of my main argument against the eliminativist camp[7]: we need intentional psychology; we need to pay attention to the content of what people are going through

[7] Of course, one can no longer say "the" eliminativist camp, since it has already disbanded somewhat since the inception of this project, with the departure of Stephen Stich.

in order to make sense of their behavior and help change it; and so we aren't going to give it up. At least, we better not. With that as a preliminary sketch of "The Case ***for*** Belief" to be presented, let me now describe the nature of the individual contests to be discussed in Parts II and III.

Part II deals with the challenges and criticisms of Stephen Stich, who exploits some of the intuitions of the "wide" philosophers and draws upon formal and linguistic models and the research paradigm in cognitive science known as "computational psychology" to propose an alternative but "narrow" paradigm of his own: the "Syntactic Theory of the Mind" (STM). In Stich's view, the practice of psychology has no need of the alleged content of the propositional attitudes – it can get by with a purely formal approach that maps our cognitive states without bothering to interpret what they may be about, and it would probably be better off doing so, since interpretive approaches are far too "parochial" or limited in scope, at least as compared to the syntactic (or quasi-grammatical) approach he advocates. Since interpretation is, as one might say, the very heart and soul of what intentional psychology is all about, Stich's implicit challenge is thus either that we don't need clinical psychologists, or that clinical psychology needn't be intentional psychology, and mental health practitioners don't have to bother to really try to understand others' mental states in this way in order to help them.

Each of these claims is false, in my view, and I shall explain why in Part II's Chapters Four and Five. First, I will consider how well the Syntactic Theory would do as an applied, clinical practice. After explaining the importance of content in clinical settings and detailing the serious practical limitations of STM and related behavioral methods of control, my conclusion shall be that STM would most likely do quite poorly, at least when it comes to providing powers of control, so it is highly unlikely that it would be able to replace intentional approaches, even if it were adequate as a descriptive account (which I'll argue it's not). Then, in Chapter Five, I will respond to Stich's objections about the limitations inherent in the method of narrow content ascription and understanding, arguing that it isn't nearly so parochial as he makes it out to be.

Having, I hope, dispatched my sociolinguistic, syntactic, and behavioral foes in the first two parts of the dissertation, in Part III I will go on to argue that is also unlikely that neuro-psychology will be able to replace the services of intentional psychology outright, in response to the challenges of the more neurologically minded eliminative materialists, the Churchlands.

As we'll see, the Churchlands not only predict that intentional psychology will some day go the way of phlogiston and the crystal spheres and other "folk" theories, to be replaced by a theory with superior scientific virtues, but they also fault it for being limited in practical application, not only with regard to the types of behavior or cognitive processes it can explain, but also and more importantly with regard to the people it can help. In particular, P.M. Churchland (1988, pp. 46, 145) alleges that folk methods aren't of much use when in comes to understanding and controlling mental illnesses, whereas even now these conditions can be satisfactorily controlled by psychiatric medications such as antidepressants.

After responding to the Churchlands' secondary arguments for eliminative materialism in Chapter Six by reviewing the important developments within the intentional paradigm, I'll go on to address the matter of both intentional psychology's and neuropsychology's understandings and

treatments of mental illnesses head-on in Chapter Seven. Leaving psychoses aside for a forthcoming project, I'll be concentrating on the most prevalent form of these so-called mental illnesses, "simple" or unipolar depression. After describing the condition, I will evaluate and contrast the intentional paradigm's methods of treating depressed people – with respect, understanding, and reasoning – to neuropsychiatry's approach, which is to drug or shock them. Not only will I be detailing the effects, side-effects, and limitations of antidepressants and shock therapy, but I'll also be reporting on the effectiveness of the short-term form of psychotherapy known as cognitive therapy and responding to ethical concerns about psychotherapists and their methods. Finally, as will come as no surprise, I will conclude that the paradigm of narrow intentional psychology is in fine shape, and that it much more likely and desirable that it will continue to flourish than it is that it will be eliminated.

That also concludes this subsection's brief synopsis of my dissertation's contents, but now, for the benefit of readers who might think it is all well and good to come to the defense of intentional psychology but who might be wondering nonetheless why a ***philosophy*** dissertation should be taking such a pragmatic tack, I shall justify and explain my defensive strategy further in this next Section.

Why Focus on Abnormal Psychology and the Pragmatic Issue of Treatment or Control?

In a dissertation about the importance of content-based propositional attitude explanations in intentional psychology, it might seem as though I will be going fairly far afield as I describe and discuss abnormal psychology, mental "illnesses," clinical psychology, psychiatric medicine, and practical treatments – topics not ordinarily dealt with in academic philosophy. Since some philosophers might wonder why I'll be examining ***ab***normal psychology in order to defend intentional psychology and underscore the need for interpretive analyses, or why I place so much emphasis upon the pragmatic issue of a paradigm's practical utility, anyway, perhaps I should say more about why I have chosen this route.

To begin with, I have two important and related reasons for focusing on abnormal psychology. The first, which is of a more theoretical nature, grows out of the important observation which has been made not only by Kuhn (1962) and other historians and philosophers of science, but also by astute clinicians such as Freud: paradigms can be made or broken on the basis of paying attention to the anomalies and puzzles. As we'll see in Chapter Six, the theory of the unconscious – one of the most profound developments in intentional psychology ever made – only really got underway once investigators such as Freud keyed in on explaining anomalous phenomena such as the "glove anesthesia" of some hysterics, where the mind numbs hands in ways no nervous damage could.[8] Similarly, a closer scrutiny of some of the more bizarre behaviors of our fellows may lead us to an increased understanding of some of the more idiosyncratic aspects of our own personalities, and this understanding of the way our identities work or break down may prove to have important theoretical implications for intentional psychology as a whole.

[8] Concerning Freud's exploration of phenomena such as "glove" anesthesia, see, e.g., Rosenhan and Seligman (1984, pp. 252, 255), or Freud ***SE*** III.

My second reason for examining abnormal psychological conditions and how they are understood and treated is of a much more moral and practical bent: quite simply, the matter warrants examination, since it concerns miserable people who desperately need some sort of help for their problems, and it behooves us as responsible members of our community to make inquiries on their behalf into the quality of the care that they would receive at the hands of the paradigms at issue. As we'll see, although the conditions we'll be examining may be *abnormal*, they're certainly not ***rare***: the fate of ***millions*** in our society alone hangs in the balance. So, because I want society to avoid the twin evils of providing no treatment for mental health problems at all,[9] or providing too many counter-productive sickening treatments, I propose that we had better take a serious look at what we would be headed for if the services of intentional psychology were to be removed from the mental health care field, and I shall be advocating that we cleave to the sensible middle course provided by intentional psychology, instead. Unfortunately, however, academic psychologists and philosophers have tended to be far too academic when debating "the future of folk psychology," largely ignoring the kinds of problems intentional psychology helps with, as well as the more untoward aspects of the types of "more scientific" psychologies they want to advance. I want to rectify that situation by bringing home to everyone a sense of the very serious consequences of paradigm shifts when dealing with applied sciences of this sort.

But why is it appropriate to pursue such a pragmatic and empirical defense of psychology in response to eliminativism (rather than, say, a transcendental one)? There are two reasons, as I shall explain: eliminativists attack psychology on pragmatic grounds in the first place, and that may be the only court of appeal their approach will admit, in the second.

First, although it is not always clear whether eliminativists are merely ***predicting*** that intentional psychology will be displaced and replaced by a more comprehensive theory with superior scientific virtues, or actually ***prescribing*** that it should be, post-haste, it will become clear as we proceed that they are attacking "folk" psychology on pragmatic grounds when they complain about the limitations of its interpretive methods. Complaining that empathy's scope of application is limited to a circle of more or less normal people with backgrounds similar to that of the 'investigator,' the eliminativists, too, have focused not on normal, everyday cases, but on problem cases, where the resources of intentional methods are strained to the utmost. In fact, as we'll see, they have underscored their charges by parading whole processions of confusing or confused people, ranging from young children to schizophrenics to the senile, who are seemingly 'beyond the pale' of the "me-and-my-friends" methods of folk psychology.[10] The attitude of the eliminativists who raise these sorts of cases is apparently that folk psychologists, even professional ones, aren't even particularly good at what they try to do, and that many abnormal subjects would probably be better served by approaches that didn't have to try to make sense of them. The section entitled "Arguments for Eliminative Materialism" (in Churchland 1988, p. 46) sums it up when it faults folk psychology on the grounds, "We do not know what *mental illness*

[9] Concerning the lamentable state of the American mental health scene, which has let substantial numbers of seriously mentally ill people fall between the cracks such that they receive no treatment or care whatsoever, see, e.g., E. Fuller Torrey's ***Nowhere to Go*** (1988).

[10] See Stich (1983, *passim*) (or my Part II) concerning the limitations of our "parochial" and "Protagorean" methods of content-ascription, although the phrase "me-and-my-friends" was coined by the Churchlands (1983) to characterize Stich's critique.

is, nor how to cure it...[once we leave normal brains the descriptive and explanatory inadequacies become starkly evident." In other words, eliminativists add the injury of the charge that folk psychology's services aren't very good, anyway, to their insult that some day those services will no longer be needed; both are pragmatic attacks.

If I am to successfully defend intentional psychology, I must confront these claims directly, since the charge that it is unable to understand or help control significant portions of the phenomena within its domain is probably the most serious allegation that can be made against an applied science or paradigm. Such pragmatic attacks have to be met on their own terms, however – on pragmatic grounds. Without such common ground, the debate would degenerate into nothing but mutual question-begging. Therefore, to evaluate the substance of the eliminativist claims and charges and the relative merits and prospects of the disputing paradigms, it is appropriate to investigate and gauge how well they do on pragmatic dimensions, such as their success in treating psychological problems. Given that they consider themselves to be faithful to the spirit of good American Pragmatism, the eliminativists will probably be only too happy to decide the issues dividing our respective paradigms according to the eminently practical policy that we should adopt (but not necessarily believe[11]) those theories that are ***useful*** and continue to make a difference in our lives.[12]

Indeed, eliminativists might even have no other recourse ***but*** to contest the issues ***solely*** on pragmatic grounds, as I mentioned. The reason for this is that eliminative materialists don't seem to be able to get to "the Truth" by their own admission, since truth only attaches to meaningful propositions or propositional attitudes, and they apparently deny the existence of meaningful propositional attitudes or beliefs. However, because I share the Churchlands' suspicion of *a prioristic* and *transcendental* approaches, I don't want put too much stock in this type of argument, which trades on the somewhat oxymoronic observation that eliminativists apparently believe there are no beliefs. Moreover, I also recognize that the fact that eliminativists may have difficulty consistently asserting their own position fails to show that the intentional paradigm is true, or that we do have beliefs. Let us therefore put aside the question whether this has to be an ***exclusively*** pragmatic dispute on the eliminativist account, assuming that we do agree that it is at least *primarily* a pragmatic concern.

On pragmatic grounds, I shall argue, the evidence overwhelmingly favors folk psychology's survival, and shows that it is a serious mistake to suppose that it will be replaced by something better. But how can I justify my emphasis upon the pragmatic issue of powers of control, in particular, considering how that will bias the proceedings right from the start? By ranking one scientific virtue – powers of control – above the others, I'll be claiming that we should keep intentional psychology around if it is useful, ***even if*** it ranks low in some of the other virtues that are favored by eliminativists. A reasonable objection here might thus be that my ordering is too

[11] While pragmatists *accept* theories and *apply* them, they don't necessarily *believe* them, since some (e.g., van Fraassen 1983) are *instrumentalists* who use theories without professing to believe them, while other pragmatists (the eliminativists) purportedly have no beliefs at all!

[12] As we can see in works such as P.M. Churchland's (1979) and (1990), the eliminativist challengers appeal to pragmatic scientific virtues such as simplicity and predictive power in preference to the more traditional goal of "Truth" or abstract correspondence with reality, and they even flaunt "the Truth" with subtitles such as, "Why Should We Care If Our Beliefs Are True?" (see Stich 1990).

biased or idiosyncratic or that it would be too arbitrary to arbitrate the dispute primarily on the basis of such a patently normative standard as the appeal to utility, so let me deal with that complaint right here at the outset.

As the first step to seeing why a paradigm's practical utility or powers of control should count for more, consider the main goals paradigms are meant to subserve. Scientific paradigms are traditionally expected to provide us with powers of *prediction*, *explanation*, and *control* in the domain of the phenomena they address, so we should assess conflicts between rival paradigms along those dimensions. The last – control – is the most appropriate one to focus on, however, for two reasons. First, it is probably the most important one as far as the community that supports the sciences is concerned; and second, it encompasses the other two aspects, anyway. Let's consider these in reverse order.

Psychology's province, of course, is ***behavior***, primarily human behavior. Now, although I join Fodor (1981, e.g.) in thinking that intentional descriptions of purposive behavior do have a lot of predictive power (despite the fact that we are often unpredictable) and I will certainly be urging that intentional explanations give us a rich understanding of human agents, I will be centering mainly on the issue of control as the most important virtue to focus on in adjudicating between rival applied paradigms in deference to the legitimate expectations of the community they would serve.

Simply put, having practical applications is the whole point of applied sciences, it is their mandate or *raison d'etre*, so their powers of control are their most salient feature. This isn't just a matter of definition, it's a matter of sound public policy, so far as the communities that financially support and utilize the applied paradigms are concerned, since we legitimately expect them to be of help when we develop problems in their area of expertise. Despite the opinion many scientists hold of the "lay-public," ultimately, we are the ones who support and maintain scientific and medical paradigms, and it our preferences that will determine whether a practice will flourish or be eliminated. From my vantage point as a member of that "lay-public," I submit that when our health ***and*** our tax dollars are on the line, informed voters and consumers are unwilling to sacrifice utility for the sake of the more abstruse theoretical virtues Churchland (1981) favors (such as a theory's consilience or compatibility with other sciences, or its amenability to quantification), given our widely held and emphatic conviction that theories that can provide essential services within tolerable margins of safety are to be preferred over more pristine or unified theories which may have more elegance but are useless or have dreadful effects. Consequently, if it turns out that intentional psychology is more useful in helping people with their problems than not – even if its explanations are somewhat suspect or if it's not particularly good at predicting what we'll do next – then our community will probably keep it in operation indefinitely, in which case the eliminativist prediction will simply be mistaken.

However, these matters of explanation, prediction, and control aren't really quite so easily pulled apart as this, which brings us to the second reason for focusing primarily on the competing paradigms' powers of control: the latter subsumes the former goals, anyway. Not only is it generally the case that our attempts to control some phenomenon are based upon our understanding of that phenomenon and our predictions about how it should respond to our interventions, but this is particularly true when it comes to applying psychological theories to

individual behavior, where explanation, prediction, and control converge into one goal – the attempt[13] to master people's psychological problems. As we'll see, theory and practice are bound together to a considerable extent in applied intentional approaches such as psychoanalysis, as many commentators have observed,[14] and understanding, prediction, and control are inexorably linked in psychotherapy, since therapists try to change people's attitudes via the process of coming to understand them, and their attempts to help people control their lives better are based upon their predictions about what to say or do in order to be helpful. Moreover, I'll be arguing throughout the dissertation that the satisfactory mastery of our problems requires an adequate understanding of our reasons for behaving, since the powers of control provided by approaches with an insufficient understanding of people's problems are either inadequate or unacceptable. But before I get too far ahead of myself here, I shall just recap my main argument in favor of intentional psychology, before proceeding with the actual evidence.

The central thrust of my pragmatic argument in defense of narrow intentional psychology is this. Competing paradigms are and should be gauged according to their problem-solving ability. If one approach is to edge out another (as opposed to supplementing or co-existing with it) and represent rational or genuine scientific progress, it is incumbent upon it to ensure the delivery of at least as many (net) practical benefits as its predecessor provided, either by performing the latter's former duties itself, or by subcontracting them out to some other discipline; otherwise, it would be precipitous to abandon it. If psychotherapy, the professional application of intentional psychology in clinical settings, is to be eliminated from the field, then some other theoretical framework must fill the void using something other than projective understanding. Therefore, in order to put the eliminativists' prediction or prescription to the test, and vindicate intentional psychology from the charges concerning its inadequacy in some of the very areas I shall be arguing it is most needed, I shall set about establishing that even in – perhaps ***especially*** in – the problem domain of the so-called "mental illnesses," we ***do*** need intentional psychology for its powers of control. Thus, I'll be arguing that the eliminativists' *prediction* that intentional psychology will be eliminated is false, since we need professional intentional psychologists to help us with our psychological problems and are likely to continue to in perpetuity, and I'll also be counseling that, to the extent that they are made on the basis of a lack of regard for the relative importance of utility and a disproportionate reverence for other more theoretical virtues, the *recommendations* of eliminative materialism should simply be disregarded, since they don't reflect our considered interests.

More Detailed Overviews

Overview of Part I: Narrow Psychology and Wide Content

As mentioned, Part One will clarify the position that clinical psychology's theoretical models fits in philosophical space, in response to the claim made by some philosophers that the content of our psychological states does <u>not</u> *supervene* or reside (entirely) in our individual brains. Since

[13] Unfortunately, however, as we'll see, when the attempt to predict, explain, and control an individual's behavior fails, at best we succeed only in mastering subjects while misunderstanding the real nature of their problems.

[14] Concerning the close links between theory and practice in psychoanalysis, see, e.g., Sutherland, in Dongier and Wittkower (1981, p. 100).

that may seem to be a strange place to start, I'll start by doing a little stage setting to sketch the landscapes in which it arose, taking you on an excursion into the areas of 20th century philosophy of language, mind, and psychology. Since I promised to spare you details to begin with, I may be taking a few liberties in the presentation as I blend together the related issues of meaning, mental events, and the mind/body problem.

For our intents and purposes, the 20th century began in 1892, at least so far as analytical philosophy is concerned, the year that brought Frege's brilliant (1892) paper, "On Sense and Reference." Among its many distinctions,[15] it distinguishes between, the ***sense*** (or "meaning," or "intension," according to related traditions within the Intentional paradigm being defended) of expressions such as "Evening Star," and their ***referents*** (or *denota*, one might say – the things it talks about). We know that the sense of that expression is roughly, 'the-star-you-see-in-such-and-such-a-place,' but what ***is*** that, exactly? A ***Sense*** (if we are to hypostatize), if it *is* anything, exists (or perhaps "subsists") as some sort of "ideational" item[16] bearing that intentional content. An expression's ***referents***, on the other hand, are usually[17] a whole different kettle of fish – they can and apparently do exist as independent physical objects in the external world; in this instance, of course, it even *is* an external world: Venus! Pointing out that what a word means is one thing and what it designates or names is another seems to give everybody what they wanted – there can be a real external world that we're talking about, alright, but there can also be meaning even in our material world if we were just capable of "grasping" these "Senses" to make our signs significant.

But so far as the "hard-core" materialist critics have been concerned, "grasping" after Meaning only amounts to straws, unless there could be some way of carrying it out or implementing it. And while most Intentionalists supposed that somehow or other the brain was capable of such understanding, they were unable to satisfy this basic metaphysical challenge of the growing number of physicalists and behaviorists who thought that such an appeal to inner cognition was disreputable and unverifiable. As if this were not enough, the materialist chorus challenging intentional realists to explain how brains could possibly be capable of truly thinking has often had the accompaniment of the harpings of *dualists*, *anti-realists*, and *instrumentalists*, as well. From Descartes, in the 17th Century, through Brentano early in the 20th century, right on up to Kripke in the 1970's and 80's, analytically inclined and seemingly logical philosophers have argued that physical things can't really think because physical things and mental things ***necessarily*** fall into distinctive categories (see Brentano 1960, Kripke 1972, Schwartz 1977), or they have urged that we shouldn't mistake reasons for causes (e.g., see Dennett 1969).

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[15] Therein lay its brilliance, of course, since the drawing and redrawing of distinctions is one of philosophers' most important tasks.

[16] Unfortunately, Frege did not hold that "senses" are ideational in the sense that they are psychological events, such as "intended meanings," or anything like that; he is, after all, the harshest critic of "*psychologism*." However, as I'll be arguing in Chapter Five, a sense-based or Intentional theory need not subscribe to Frege's version of Platonism, which posits an independent realm of Ideas and necessary truths. Instead, the states Frege calls "the modes of presentation," which are psychological events and processes (such as the images associated with a word) can be adapted to the purposes narrow psychology needs.

[17] Referents are usually or often physical objects or events, but not always, if the Platonists are right that some referents apparently are Ideas, Senses, or Numbers, etc., but even they grant that we can't see how on Earth that could be so.

With criticisms such as these on its back, things didn't look too good for intentional psychology for a while, at least in academic psychology. With the advent of the computer age, however (which, somewhat ironically, given his opposition to Husserlian or "psychologistic" approaches such as the one being represented, was probably greatly hastened along as a direct result of Frege's pioneering efforts in symbolic logic), things started shaping up tremendously.

As increasingly sophisticated and very physical symbol processors were developed, and more and more people began to accept that we are literally "organic computers," the phrase "mind-brain" seemed less of an oxymoron and more of a redundancy as time went on. The insights of Computational Theory, which blends causality with symbolism, seemed to provide the solution to the metaphysical puzzles at last. Computers can, after all, not only *grasp* symbols (or pyramids, or almost anything else we want them to), but also process, manipulate, calculate, and compute with them, so maybe our brains are capable of making sense after all, since the Senses we understand might just amount to symbolically encoded *definitions* and *descriptions*, as those in the Fregean tradition from Russell (1919) to Searle (1958, 1983) have alleged. Thus, we seem to have come to our happy resting place – a philosophically defensible account of meaningful states – in one fell swoop: meaningful thinking can be carried out via the manipulation of things such as sentences in our computational brains.

That, at least, was the position of influential M.I.T. works such as Fodor's 1975 classic, ***The Language of Thought***. Thus, despite the continuing protests of critics such as Dreyfus (the author of "Why Computer's Can't Think") and Searle (1980, who doesn't think that computers 'have what it takes' to really be able to interpret symbols) to the contrary, many in what is now called the cognitive science community came to believe that computers had managed to solve the philosophical problems such as "Brentano's Problem" and the "mind/body problem" along with its many other accomplishments. This by now familiar successor to the clockwork model of the mind came to be known as ***functionalism*** in the late 1960's, in accordance with its view that cognition is the result of the systematic functioning of complex systems, however they happen to be composed. Its articulation culminated in Fodor's **Representational Theory of the Mind** (see Fodor 1981, which built on Fodor 1975), or "RTM," which was intended to breach the gap between the physical and the mental once and for all, with its claim that propositional attitudes are actually ***computational*** states, i.e., processes or states bearing semantic relations to one another and to the world that are organized in such a way as to be capable of respecting logical relations such as entailment. (They show their respect by executing logical operations.) Moreover, as Fodor (1980) observed, the computational story's emphasis upon ***internal*** symbols and representations has an added twist: ironically, for a theory comporting with materialism, it has the virtue of preserving the basic Cartesian intuition that intelligent behavior can be explained by mentalism, by an appeal to the *subject's* conceptions of what is going on – however chimerical or illusory they may be – to account for purposive behavior.

Thus, by the mid-seventies, the situation in the mainstream Anglo-American philosophies of language, mind, and psychology, seemed to be following: the mind-body problem was solved or dissolved by the claim that our minds are organic computers; "folk" psychological explanations had integrity after all – we really do act because of our attitudes, which are chugging away in our brains; and so we had a philosophically defensible explanatory paradigm for behavior to serve as an alternative to the strictly physicalist and behavioral ones that had been emerging.

Philosophical challenges, however, have a habit of reappearing, and they aren't easily put to rest, so more troubles soon loomed for the view of the intentional realist that our psychological states are actually just a certain type of complex processing in our brains. Some of these more recent challenges have been put forward by some of the very founders of the functionalist position, such as Hilary Putnam, who has joined others in arguing that computational psychology is unable to realize both of the goals it seeks to attain.

In order to serve as a theoretical foundation for realist intentional psychology, computational psychology in practice has to attempt to realize at least the following two explanatory goals: one is to explain our behavior by sticking to the facts (rather than just proffering mythical narratives or "Just-So" stories), by describing the organization of the internal states which are causally efficacious in producing it and referring only to *bona fide* causal processes; the other is to is to characterize what the subject feels, wants, and believes.

Although the "reasons are symbol manipulations" approach once seemed to accomplish both objectives, Putnam and many other philosophers now argue that these goals pull in different directions, drawing on their observations and hypotheses about how language and intentional explanation and interpretation work. ***If*** they are right, it would appear that intentional psychology filtered through computational psychology must divide into two independent disciplines: "sub-personal" or "sub-doxastic" psychology, which explains behavior in strictly computational, syntactic, or otherwise physical terms, by uncovering the mechanisms underlying behavior; and the discipline Putnam (1983) calls "Interpretation Theory," which offers content-based or semantic characterizations of what these states and mechanisms are doing.

This bifurcated view actually leads to three scenarios, none of which are friendly to my paradigm. Either the interpretation of the putative representational content of mental states is not relevant to a causal explanation of the behavior, and a complete explanation can avoid intentional content altogether in favor of more computational or formal *explananda* (this is Stich's view, to be discussed in Part II); or else an explanation limiting itself to causal factors within the boundaries of the organism cannot be a fully intentional one (that seems to be the view of Burge (1986), as we'll see in Chapter Four, who notes that his views about language and content-ascription are compatible with a causal account which takes into account the contribution of the surrounding community to cognitive content). A third conclusion which can be drawn from this externalist analysis (which sees meaning as a function of reference, instead of the other way around, and emphasizes the contribution of the community in which the interpreted subject is embedded and its conventional standards of attribution) is that Intentional explanations are not truly causal explanations (this view is espoused by Putnam 1983, who endorses a Davidsonian view to the effect that "Interpretation Theory" is a normative, holistic affair, not a literal or causal description of events).

Since each of these positions are opposed to the one I'll be defending, I must address the main concerns and arguments that are behind them. "Externalist" or "wide" approaches to language and meaning advance the socio-linguistic project of treating language as an entity somewhat autonomous from individual language users. Many such theories advocate so-called "causal" theories of reference (which stress the importance of the connection between words and the

external objects they have been used to name), mixed with a story about the contribution that the wider community, especially its experts, makes to the meaning of our shared language. The favored bottom line of "wide" philosophers of language is, "Meaning just ain't in the head!" – i.e., they maintain that the content of the propositional attitudes that underlie many or most of our speech acts or other behaviors is at least partially a function of extra-cranial links to the ostended world and/or to the linguistic community which "grounds" word usage.

In support of their view, "wide" philosophers employ something known as "Twin Earth" arguments: they submit that while physically identical twins or *doppelgangers* on parallel worlds would have to be counted as equivalent so far as narrow psychology is concerned, they might actually be thinking about different things on their respective planets, so they should be counted as having different attitudes, in accordance with our (alleged) practice of ascribing content on the basis of the surrounding community's language usage. One 'Oscar' could be thinking about water, for example, while his counterpart contemplated some watery but distinct substance, despite the fact that their brains were functioning identically, which seems to suggest that thought isn't just a matter of brain functioning.

So how will I be responding to these "wide" arguments? Mainly, I shall claim that they miss the point – the point of individual intentional explanations, which is to discover what the subject's view of things is to understand his behavior, not to consult dictionaries to determine what experts would mean by the words subjects happens to use. Although I will be granting the soundness of some of their intuitions, observations, and arguments, I will also be bemoaning the fact that they are misapplied, and urging that they be recognized as contributions to sociolinguistics, rather than to intentional psychology. In addition to explaining why wide theories are both insufficient and inappropriately applied to the area of individual psychology, I will describe how and why intentional psychologists can and should adopt a narrow approach.

With that overview of the terrain of Part I, I shall now briefly run-down the contents of its individual chapters. This, of course, is ***Chapter One***, it actually begins with Chapter ***Two***:

Chapter Two: Developments in the Philosophy of Mind and Language

Chapter Two will provide a more detailed version of the relevant history of the philosophy of mind, language, and psychology that was just given – from Frege's Senses through description theories' definitional sentences to Fodor's ***Language of Thought***, culminating in the "Twin Earth" challenges to narrow intentional psychology, which allege that two physiologically identical subjects could have different thought contents if they were located in different contexts, so contents (and concepts as well, according to Putnam 1983[18]) are not simply a function of the way a brain is organized, but depend in addition upon external causal links joining words to their referents, and upon the practices of the community the subject is embedded in.

[18] Putnam (1983, p. 154, his italics, my underlining) uses "Twin Earth" arguments in support of the view that, contrary to what the remaining advocates of Artificial Intelligence and functionalism may think, "...there may be *sentence-analogs* and *predicate-analogs* in the brain, but not concepts."

Chapter Three: Is Narrow Intentional Psychology Impossible?

This chapter begins by setting out the philosophical problem confronting "narrow intentional psychology" in high relief. The explanations of "narrow" psychology, recall, are to abide by the constraint Fodor (1981) calls "Methodological Solipsism," which enjoins investigators to explain behavior by adverting to factors within subjects' heads that are actually in a position to cause that behavior; but the explanations of intentional psychology are also supposed to advert to contents, such as Hinckley's notorious belief to the effect that, *Shooting Reagan would attract Jody Foster's attention!*). If narrow psychology is to accomplish both objectives, the content of the psychological states being referred to must somehow be located inside the head. As we saw, that "supervenience" requirement can be met, if the meaning of someone's attitudes is located in "***senses***" which can be "grasped" or internalized by our brains, or if it arises as a function of the internal relations of the sentences and sensations embodying those attitudes, but since neither of these is the case, according to the wide analysis, narrow psychology seems to be deprived of the intentionality it needs. Furthermore, some commentators have gone on to submit that even if there were some sort of genuine intentional content that did supervene on the individual subject, we would be unable to convey that content in natural language, which communicates ***wide*** content, and they draw the pessimistic conclusion that "narrow" content – even if there were such a thing – would be *unspeakable*, so narrow intentional psychology simply can't be done.

In response to this allegation that narrow intentional psychology is a hopeless non-starter, Chapter Three will draw upon Stich's (1982, 19833) analysis of the ascription of content, Dennett's (1982) discussion of narrow or "notional" content and belief, and Brian Loar's (1986, 1987) distinction between what he calls *social* content and *psychological* content, in order to describe and illustrate how behavior can be explained in terms of narrow content that can be reported using everyday language that has the referential or wide parts that the subject is not cognizant of or influenced by "bracketed" (as Husserl puts it) out.[19]

Then, at the end of the Chapter, I'll be ironing out some of the wrinkles in the practice of making content reports confronting the narrow intentional psychologist by discussing issues such as whether a difference in the truth-value of the claims implicit in two reports implies a difference in their intentional content, and explaining the differences between what philosophers call *de re*, *de dicto*, and *de se* content, and indicating how indexicals (such as "I," or "there") are to be handled in narrow explanations.

The Inadequacies of Wide Approaches to Individual Psychology

Next, to point out the shortcomings of exclusively "wide" approaches to language and individual cognition, I will not only counter that causal and social theories can neither adequately accommodate such "pragmatic" phenomena as "speaker's reference" (or "intended meaning") nor explain how it is that we comprehend language unless they employ the resources of "internal" or intensional theories of the type being defended (which explain meaning in terms of the representational concepts and networks in language users' heads), but I will also argue that wide

[19] For example, we might explain why a child hangs his stocking in terms of his fanciful notion, [Santa Clause will come fill it!], being careful not to attribute the skeptical and cynical views of the community on that subject to him too soon.

attributions have the very real potential to seriously misunderstand what individual subjects really mean by what they say and do.

Wide Meaning Needs Narrow Meaning

The thrust of the first argument and section of Chapter Four will be that "wide" theorists has better acknowledge that narrow meaning is possible, since their own account is radically incomplete without it, for several reasons. Since they take themselves to be giving an account of meaning, rather than trying to eliminate it from our explanatory ontology, the "wide" content people need to posit psychological events, too, in order to explain how we are capable of understanding meaningful messages, and by their own admission at least some of these must have intentional properties which inhere in or supervene on the individual: language users must have certain categories (e.g., 'animal' or 'thing') in mind in order to become competent in the use of names, nouns, and (other) descriptions – especially the people who named the things in the first place; in addition, I'll point out that Burge, Putnam, and Kripke all grant that individuals have their own private associations and misconceptions – indeed, they exploit these "misconceptions" in order to launch their theories; and, because we think about plenty of unreal properties or constructs, too, in our mathematical, religious, and metaphysical reveries, I shall argue that even the causal, empirically minded philosophers probably have to come up with some sort of "intentional inexistence" story to explain how such notions are meaningful despite the fact that they don't refer to anything; and I will point out that the public, social story encounters difficulties once we recognize that the content of an expression often *starts out* subjective (e.g., for some time the meaning of "relativity theory" was whatever Einstein thought it was), and that it is usually far from determinate what *the* official meaning of an expression is, since, apart from stipulative definitions and rigorous artificial logics and languages, there are active disagreements about the meanings of terms and their applications even among the experts (as, e.g., Cicoerel has showed in detail), which suggests that even in the social sphere everyone has notions of their own.

Wide Intuitions Miss Generalizations

In the second major section, in rebuttal to the suggestion made by Quillen (1986) and others that "wide" attributions are "tailor-made" for the purposes of intentional psychology, I will articulating and fleshing out the import of narrow psychology's position that "Twin Earth" intuitions and wide construals individuate psychological contents too finely, thereby missing generalizations across situations that are cognitively or psychologically equivalent from the subjects' points of view, despite differences in their environments or linguistic communities.

Wide Psychology Misses the Boat

More importantly, however, in the more extensive Section Three, I will be submitting that a psychology which violates the solipsistic principle in the way that the wide or "extensionalist" philosophers suggests would be unable to properly do its job as individual intentional psychology, which is to determine and explain the *subject's* reasons for acting. In short, my position is that wide psychology is a bad way of going about giving individual intentional explanations. When explaining an individual's behavior we're not trying to characterize the

Zeitgeist of his society (though of course that has been an influence in forming his opinions), we want to know what *he* thinks, not what the experts around him might mean by the words he uses.

In support of that claim, I'll make a brief excursion into the fields of developmental and clinical psychology and the animated and often bizarre worlds of children and schizophrenics, to describe cases where subjects are best understood *not* by rendering a conventional interpretation of the words they happen to use, but by trying to see things from their point of view. But why should I discuss incompetents in response to the philosophers who usually confine their discussions to normal, competent speakers? There are two good reasons.

The first is pragmatic, and most urgent – like it or not we do have to make sense of the speech and behavior of incompetent or non-competent people, too. So while "psychology is not a monolith," as Burge (1986) puts it, it seems evident that at least part of intentional psychology – the parts dealing with the attitudes of psychotics and children --- must adopt a narrow point of view.

The second reason, although it extends the pragmatic argument, is more theoretical. Here, the claim is that the rest of us aren't so different – we too "have our own take on things," and "live in a world of our own," and those inner worlds are the target of individual psychology's inquiry, not what the surrounding textbooks and dictionaries say someone's words mean. Granted, psychology is not a monolith, and for different questions, different information is pertinent; but when it comes to *individual* intentional psychology as a whole, whose explanatory mandate it is to uncover the individual's reasons for acting, it sure looks like it should be narrow, if we're going to try to apply it to the considerable numbers of people who diverge from the views of the "experts" and the "norm." Of course, *aspects* of clinical psychology are wide, such as the "frame" of the explanatory situation (which includes the outward description of the behavior, and an 'objective' diagnosis), but the *content* of the explanation should be narrow if it is to be fully serviceable.

My strategy in this section, then, is to focus our attention on more troublesome cases than the examples that are discussed in the conventional philosophical literature (such as astronauts collecting water (or "XYZ") samples, or patients wondering whether they have arthritis or rheumatism) in order to undermine the firmness of the "Twin Earth" intuitions and convictions about the ascription of content that have served as the main ballast of the wide program and stood hard and fast for many critics of narrow psychology. Once we recognize some of the problems involved in understanding the communications of people who are just learning our language, or who have come to invest the words they use with their own, highly idiosyncratic meanings, I shall be arguing, we'll realize that it often difficult to say just which speakers are "competent," and so frequently we have to be prepared to put the conventional or default meaning that we assign to the things people say by the boards, and use our empathic and interpretive skills instead, if we are to get at what they're really thinking and feeling.

Narrow Psychology and Phenomenology

Finally, before leaving the more philosophical part of the dissertation, I will complete the initial defense of narrow psychology with a final section which reprises once more in philosophical

terms the type of psychological model being defended. Drawing not only on Fodor (1980) and Dennett (1982), but also Dreyfus (1984) and Kockelmans (1967), I'll show that that the type of philosophy of mind that has been arrived at, a "notional world framework," has strong roots in the philosophical tradition, since it is both Husserlian or phenomenological in spirit **and** computational in implementation,[20] which makes it an excellent foundation for clinical psychology to use.

That noteworthy finding will serve as a bridge to Part II, which will argue, among other things, that such a model underlies much of the actual field of clinical psychology, which adopts a narrow but intentional point of view, so let's cross over to that part, after first surveying the terrain to be covered in the latter parts.

Transition to Parts II and III

Next, after I have clarified my paradigm's position in philosophical space in Part I, I shall be conducting the proceedings in Parts II and III like a trial or inquiry, recording the testimony of the relevant psychological and medical expert witnesses, inviting the reader to judge the relative merits and prospects of three paradigms: the defendant, clinical psychology; and two disputants – the formal models of cognitive science, represented by Stephen Stich, and the neurophysiological and pharmacological models and methods, championed by the Churchlands.

While I will be pursuing the philosopher's traditional goals of wisdom, truth, and the good, I shan't pretend to be nonpartisan, however. But why adopt an adversarial role – why the Inquisition, instead of merely the philosopher's more traditional dialectical inquisitiveness or studied neutrality? Although I am certainly not employed or remunerated in any way by intentional psychology, I shall be advocating its use, so naturally you should expect me to deliver an investigative report that is loaded in my paradigm's favor. And so, I hope, I have; but let me tell you how and why.

It seems only appropriate to endeavor to present as favorable a case for intentional psychology as possible, in response to books with subtitles such as "The Case Against Belief" (see Stich 1983). It is eliminative materialism, with its talk of eliminating content from psychology, which places us in adversarial roles; ultimately, as you shall see, mine is the more ecumenical position, since I propose that we grant the needs of all three paradigms (intentional, computational, and biological), since each has important applications and can contribute to the development of the others. But because there are only so many resources we can commit to the study and treatment of behavior and mental health and there is an intense competition for those resources, according to the time honored and dishonored polemical strategy, the rules of the game are that to maintain my ecumenical position that we need psychology ***as well as*** medicine and cognitive science, I must become a trenchant critic of the practical limitations of the latter disciplines. Thus, to

[20] Although I won't be presenting the Computational view in much detail regarding its actual theories about the way the intentional processes it posits are implemented, instantiated, or realized, I will at least briefly describe the basic view I shall be defending here: according to the area known as "schema theory" in cognitive science, an organism or other sort of computational system can have intentional content built up from an interactive network of motor, perceptual, and abstract, symbolic processing loops, and thus the "propositional content" intentional psychology talks about amounts to equivalence classes of "conceptual roles" or "functional roles," as philosophers call them, i.e. to certain types of computational processes.

invalidate the claim that intentional psychology's applications can be done as well or better by the competing paradigms, part of my defense of psychology will be to go on the offensive, by presenting as damaging a case as is warranted against the challengers on the charge that their powers of helping us to control or modify maladaptive behavior are either inadequate or unacceptable.

I freely admit, however, that the adversarial role comes naturally to me after training in the philosophical academy, and that I have borne it with more zeal than reluctance, since I have serious misgivings with harmful or wasteful methods that detract from the proper use of superior methods, and I want to curb their unrestrained development or use, which would take place at the expense of psychology's adequate support and consumers' health. Thus, I admit that these proceedings will be somewhat biased in psychology's favor, but let me now be quite explicit about the nature of that bias.

While I have not knowingly distorted the facts, I have rigged the trial in the following manner: I propose that we adopt a certain standard or rule of evidence to guide our inquiry into the relative prospects and merits of the competing paradigms in question. If I am granted it, my defense should, I think, succeed, if I have faithfully reported the experts' opinions that are to inform our judgment. The standard is this: we should decide in accordance with a policy that is employed by most sensible medical practitioners and clinicians, who adopt an eclectic, pluralist, and ultimately ***pragmatic*** viewpoint – we should continue to use what works, and we should minimize the use of methods that cause harm. That, then, will be the slant of this report – a preference for helpful methods – so consider yourself forewarrened. As I shall be arguing in more detail shortly, the application of such a principle seems to be warranted in this debate, since the paradigms under review offer ***health care*** services, which have traditionally (and with good reason) been subject to such an injunction. Contrary to eliminativists, then, as you shall see, the policy I shall be recommending for this paradigm contest won't be "Let the best paradigm win," if that means driving out the useful services of the others; my counsel shall be, "To each its proper share of services and support."

More Detailed Overview of Part II: STM vs. RTM – Can Neuroses be Treated Successfully Without Understanding the Content of People's Problems?

In this part, I respond to the challenges presented by Stephen Stich. Like Fodor (1980), Chomsky (1980), and others, Stich (1983) advocates "Computational Psychology," a research paradigm that has emerged in the cognitive sciences which has developed certain purely formal models of language and cognition. However, unlike Fodor (1981), Stich does not believe that content does any "work" in the useful generalizations of psychology, so he urges that future, "scientific" psychology should (or at least could) divest itself of the practice of interpreting the content of our cognitive states. Instead, he proposes, the cognition responsible for producing our behavior can be mapped and explained in the purely formal style familiar to logicians and computer scientists, without needing to bother to assign any content or interpretation to the operators and symbols being manipulated by our cognitive architecture.

However, while formal analyses, descriptions, and "explanations" have their appeal, the problem with Stich's proposal is that formal approaches simply cannot get us very far when it comes to

helping people deal with their trials and tribulations, or so I shall argue, while understanding ***what*** bothers people is crucial to helping them to change their outlook and improving their lives. This argument has several parts, to be distributed across Chapters Five and Six.

Chapter Five: The Challenge of Syntactic Psychology

Chapter Five begins by introducing us to a large segment of the problem domain. Section One will review the clinical literature on some of the major life disturbances that affect us adversely. We'll be focusing on neuroses incurred as the result of being victimized by the harsh realities of our world, especially the condition known as Post Traumatic Stress Disorder (or PTSD), in order to establish the evident and urgent need for some sort of psychotherapeutic services. PTSD seems and appropriate place to start, not only because it is fairly pervasive and is very likely going to be with us for the entire history of humanity, but also because it has elements in common with the conditions to be discussed in Part III. At the same time that I am describing the problems that need to be addressed by the contending paradigms, I will be presenting the initial stages of an at least *prima facie* case for why a content-based psychotherapy is the most appropriate paradigm for dealing with such problems

Then, in the second section of Chapter 5, I will describes how narrow, or, as I'll be calling it, "notional world" psychology understands and explains such conditions, and how it sets about treating them. I'll outline the model of the mind held in common by clinicians as diverse as Freud, Rogers, Beck, and Ellis, and countless others, and let them describe how they try to help people with understanding: by understanding what they are going through – the content of their experiences, fears, motivations, and so on; by showing them that they are understood; and by getting them to understand for themselves what their problems and possible solutions really are.

Section 5.3 will describe the challenging paradigm, STM, in more detail, and discuss how it might set about dealing with psychological problems such as these. I shall explain why the approach seems bound to fail, given what we are told about the theory and what we know about people, their problems, and how people with personal problems respond to clinical and formal (in their pejorative sense) approaches. Not only will STM be hopelessly inadequate in the matter of providing some powers of *control* that are wielded by the content-based paradigm he critiques, I argue, but it is inferior in the areas of description and explanation, because it misses important meaningful generalizations and it purchases any increased reliability or precision it might have at the expense of being able to really make sense of our behavior.

However, it is not enough for me to attack STM relentlessly to meet the challenges posed by Stich and his behavioral colleague, Eysenck; I must also respond to the charges that have been made against intentional psychology concerning its shortcomings, and defend it on its merits. I will attend to that task in the subsequent Chapter:

Replies to Practical Criticisms of Content-Based Psychology

Since an advocate of STM might respond to my line of argument by simply denying that there is any need if the services I am claiming only a content-based approach can provide, in the first section of the latter half of Chapter 5, I will draw upon the clinical and sociological literature to give some indication of the magnitude of the mental health problem and the tremendous need for

some sort of therapy. Since literally millions of people are suffering from a great many problems that desperately need help, I will be doing an end-run against any wishful thinking that might be expressed by someone who simply wanted to dispense with intentional psychology's services without providing a serious practical alternative.

Then, in the section, "Do We Need Professional Psychotherapists (Or Are They Just Expensive Friends?)," I will explain why we should continue to support intentional psychology in "serious" scientific circles, and why we should maintain a *profession* of mental health practitioners, which means providing resources for the training of psychologists in academic institutions and funds for research. If I am right about this, and our society indeed continues to abide by its current sensible (although flawed) policy of requiring its health practitioners to be duly accredited and certified, then, I shall conclude, the prediction being made in Stich (1983) to the effect that folk psychology and interpretation will be left behind in the future theory and practice of academic psychology is quite mistaken. However, since the conclusion that we are and probably will be stuck with intentional psychology won't be of much comfort to those who have serious misgivings with it, I shall go on to address criticisms about psychotherapy's scope of application and efficacy in the final two sections.

The next Section will respond to Stich's charge that the method of empathy or projective understanding is too "parochial" or "Protagorean" to be suited to our needs. Basically, my strategy for dealing with this charge will be to concede its substance while denying its force. Although I will be granting his observation that the process of content attribution involved in empathetic or projective understanding requires the investigator to compare the content of the subject's cognition to his or her own and thus entails similarity judgments, I shall contest his claims that the range of application of empathy is too circumscribed to be of much use to psychology by arguing that the limitations inherent in the method do not pose an insurmountable obstacle to clinical psychology in practice. To do this, I will attempt to defuse some of the problematic cases he presents in Stich (1983) by showing that the relevant intentional content of the subjects he describes is not as ambiguous or nonsensical as he makes out (once we become clear upon what the object of inquiry is); then I will draw on the clinical literature to show that much is now known about the patterns of thinking of even disturbed and abnormal cognizers; and, finally, I will point out that trained and experienced investigators can bring such subjects into the purview of intentional psychology by making themselves similar to them, by building on this knowledge and creating new computational spaces within themselves in order to get into their mind-set.

Finally, I will respond to the persistent charge that has been made against applied intentional psychology by Eysenck and others, who claim that its practice is no more effective than no treatment at all, even if it does happen to provide understanding. I'll examine these claims, and report on what is now known after many years of studies of the overall efficacy of psychotherapy. I will, however, be deferring the discussion of psychotherapy's effectiveness until Part Three, to which we shall now turn.

Part III: Intentional Psychology and Medical Psychiatry

Having, I hope, dispatched my syntactic and behavioral foes in Part II, in Part III I will go on to argue that is also unlikely that the other major eliminativist paradigm will to be able to replace

the services of intentional psychology outright. To evaluate the predictions or prescriptions of the neurologically minded eliminative materialists (or "neuro-eliminativists"), and realistically assess the prospects of eliminating the practice of ascribing propositional content in order to understand and modify behavior, I shall investigate the state of the relevant arts and practices in question and examine the effects, side-effects, and limitations of psychiatric treatments as compared to psychological ones. Along the way, I will be contesting some of the claims of the "medical model" of mental "illness," and pointing out the admitted shortcomings of their techniques, as well as describing psychological treatments and suggesting ways to improve them.

Part III: Intentional Psychology versus Neuropsychology

Part III will examine and respond to the claims and criticisms of what might be called "neuro-eliminativism," as represented by Paul and Patricia Churchland. Although they have spoken in favor of narrow psychology in principle in their (1983), the Churchlands aren't too concerned with whether intentional or propositional attitude psychology needs to be narrow or wide, since they have bigger fish to fry: they openly challenge whether it's even needed or will stay with us at all. As spokesmen for eliminative materialism, their view is that there will soon (maybe not today or tomorrow, but soon – or else this just is an academic debate, in the pejorative sense, which is not what they intend it to be) come a time when the theories and services of intentional psychology simply won't be needed any more, once they are edged out by a vastly superior scientific paradigm which has a deeper understanding of human beings and a greater facility to change their behavior. And as *neuro*eliminativists, they aren't just offering an idle speculation that some day something better may come along, for in works such as ***Matter and Consciousness*** (1988) and ***Neurophilosophy*** (1986) they not only allege that folk psychology is both inadequate and mistaken, but they also actively endorse and champion its chief competition, neuropsychology, with its attendant practices of psychopharmacology.

Paul Churchland (1988, pp. 45-46, 45, 146), for example, articulates the eliminativist's position in these first two passages, and the neuroeliminativist's, in the third:

> So much of what is central and familiar to us remains a complete mystery from within folk psychology. We do not know what *sleep* is, or why we have to have it...[or] how *learning*] transforms each of us...or how differences in *intelligence*] are grounded...[or] how *memory* works...[or] what *mental illness* is, nor how to cure it....[F]olk psychology has enjoyed no significant changes or advances in 2,000 years, despite its manifest failures.
>
> ...As the eliminative materialists see it, *...our common-sense psychological framework is a false and radically misleading conception of the causes of human behavior and the nature of cognitive activity*...it is an outright *mis*representation of our internal states and activities.
>
> ... *Imipramine* controls depression, *lithium* controls mania, and *chlorpromazine* controls schizophrenia. Imperfectly, it must be said, but the qualified success of these drugs lends strong support to the view that the victims of mental illness are the victims primarily of sheer chemical circumstance, whose origins are more metabolic and biological than they are social or psychological....If we can discover the nature and origins of the complex chemical imbalances that underlie the major forms of mental illness, we may be able to cure them outright or even prevent their occurrence entirely.

Thus, rather than simply expressing possibly mistaken views about the nature or methods of clinical psychology as the wide philosophers seem to, the neuroeliminativists are not only predicting its demise, but they are also furthering the interests of its main rival, medical psychiatry, in the often acute competition for resources and legitimacy. Consequently, of the philosophical opponents to narrow intentional psychology, they are a most formidable threat, since they advocate means of mental health intervention that have the very real potential to cause serious harm, as we shall see.

Although I will be criticizing it, I must admit that the neuroeliminativist's position does seem it have a lot going for it. We are, after all, merely "big-brained" creatures (in Vonnegut's phrase) similar to other organisms; and, according to my own paradigm, we are dealing here with problems that are "all in the head;" so backing the brain sciences as the most likely and desirable candidate for replacing folk psychology might seem a wise bet on their part, especially considering that psychiatric medicine, the applied extension of neuropsychological theories, is a huge growth industry currently competing with clinical psychology for the allocation of health care resources. Of the alternative paradigms we know about, somatic medicine does seem to be the most likely to succeed in eliminating the services of folk psychology, if anything can.

However, because I believe that the "success" of these drugs must be highly qualified, indeed, and because bets and predictions in this post-Heisenberg world can influence the domain they study through their effects on policy decisions, I think it's only appropriate to examine whether these bets are sound or good by investigating somatic psychiatry's methods of treating mental "illnesses," to see what we would be in for if intentional psychology's services were to drop out of the field. Accordingly, in these final chapters, I will take the bull by the horns by confronting the mental illness question directly, explaining why we now need intentional psychology even for the treatment of the so-called mental illnesses and are quite likely to continue to, at least for the foreseeable future.

But before I critique neuroeliminativism in particular in Chapter Seven, I will respond to the independent supporting arguments for eliminative materialism in ***Chapter Six***, especially the ones I'll be calling the "historical" and the "limitations" arguments. The former, which popularized the locution "folk" psychology, is presented in a variety of the Churchlands' works, which offer an historical argument to the effect that that intentional psychology will likely turn out to be radically mistaken given the fate of other primitive "folk" theories, since "it would be a *miracle* if we had got *that* one right the very first time, when we fell down so badly on all the others" (Churchland 1988, p. 46). In reply, I'll argue that intentional psychology is not as static as its critics seem to think, and that it wouldn't be so miraculous if we did understand each other reasonably well, considering that we're social creatures who have had to pay more attention to understanding the behavior of our fellows over the years than we have to other subjects, and considering also fact our introspective powers provide us with far more access to psychological phenomena than we have into other matters – first-hand knowledge (or familiarity, at least), in fact.

Next, I will address the limitations argument. Like Stich, the Churchlands charge that intentional psychology is decidedly limited in both breadth and depth. Intentional psychology's breadth limited, in that it restricts itself to a class of relatively 'macro' events, namely *actions* and other

behaviors that can be "made sense of;" as we saw above, the Churchlands point out that this leaves other matters relevant to psychology such as the actual neuromechanics of memory unilluminated. And things are actually much worse than this, they submit further, for even if we are content to confine ourselves to the intentional level, we will find that the intentional approach doesn't go very deep, since its practical resources are strained to their limits when it comes to dealing with people with abnormal or damaged brains (see, e.g., Churchland 1988, p. 46). Briefly, my response to the limitations argument will be to elaborate upon and emphasize the nature and importance of intentional psychology's status a special science, and to divide and conquer the types of cases they discuss by pointing out which cases it can be helpful with, and which ones are none of its business. Basically, I'll concede that appeals to subjects' reasons for behaving don't explain all psychological phenomena, but argue that they were never intended to, nor should they be expected to, so long as they have important applications in their domain of inquiry.

Having thus argued in previous Chapters that it's at least ***possible*** (if not actually likely) that clinical psychology's understanding of our behavior is roughly right, despite the fact that it doesn't explain everything, I'll set aside the question of Truth (which the eliminativists can't feel entirely comfortable with, anyway, as noted) to take up this issue of intentional psychology's practical worth or utility directly in the final lengthy Chapter Seven, which examines the fundamental issue underlying neuroeliminativism, and evaluates the relative prospects, claims, and liabilities of neuropsychological treatments of mental illness as compared to psychological ones.

In order to evaluate the predictions or prescriptions of the neurologically minded eliminativists, and realistically assess the prospects or desirability of eliminating intentional psychology's practice of ascribing propositional content to understand and modify behavior in favor of neuropsychiatric means, I will describe the state of the relevant arts and practices in question concerning their understanding and treatment of mental illness. Although I do believe that intentional psychology should have an important role to play in the treatment of *all* the major forms of mental illness, I will concentrate on depression, in particular, for several reasons: it's the most prevalent serious emotional disorder, and certainly one of the most dangerous, considering the suicidal tendencies it induces; it's more easily understood by lay readers, who have very likely had some serious bouts of it themselves, or at least know someone who has; and, finally, it also happens to be quite a showcase for clinical psychology, which has developed certain specialized short-term forms of therapy for depression that have been shown to be no less effective than the very antidepressant drug that was mentioned by Churchland, Imipramine.

To actually carry out the examination of the relative merits of the two approaches, I will focus on one of these specialized forms of therapy – *cognitive* therapy – on the one side, and compare its effects and limitations to neuropsychiatry's primary treatments of antidepressants and electroshock (or ECT), on the other. No doubt you already know something of the latter methods; suffice to say that I will be describing their adverse effects in detail. Cognitive therapy you may not know about; developed by Dr. Aaron Beck of the University of Pennsylvania, as we'll see, the cognitive theory of depression explains why people feel badly in terms of a *cognitive triad* of negative or pessimistic thoughts about themselves (e.g., "I'm worthless"), their ongoing experiences ("nobody likes me..."), or their future ("it's hopeless..."), while cognitive

therapists train depressed subjects how to recognize these kinds of self-destructive and fairly automatic kinds of thinking in themselves, and how to use reason to blunt or even eradicate their influence altogether. But because it wouldn't be fair or honest to fault neuropsychology for its adverse effects without taking into consideration concerns about the possible liabilities and abuses of clinical psychology, I will address these concerns in the penultimate section, examining such issues as whether psychotherapy violates autonomy or restores it, and what to do about doctors who abuse their position of trust with patients by having sexual relations with them.

Having examined and evaluated both approaches, my concluding section will submit that the intentional paradigm is not in a state of crisis and has no reason to be, and that folk psychology is not in nearly as bad a shape as the eliminativists let on. In fact, as I'll show, clinical psychology is flourishing more than ever, and it continues to be a growth industry, as well. More importantly, I will be challenging the neuroeliminativist's assumption that the paradigms at issue are mutually exclusive. In particular, I'll be arguing that although there is competition between these paradigms, alright, there is actually plenty of room for both approaches to expand, and also that, given the number of people and pressures in this world, they probably both will. Moreover, as psychotherapists such as Beck *et al*. (1979) point out, not only is it the case that the treatment methods of medicine and psychiatry aren't exclusive in the sense that both approaches are required, since drugs aren't for everyone (for various reasons, not the least of which is their side-effects) and neither is talk, but it's also actually frequently the case that medical therapies need to be supplemented with psychological methods if they are to work effectively, if only to secure compliance with the therapeutic regimen. At any rate, I shall conclude, it is unlikely and undesirable that the intentional paradigm will die out – if we know what's good for us.

In brief, my position concerning notional world psychology is this. For me, the issue isn't what intentional psychology *can't* do (e.g., explain how memory or vision works), it's what it *can* and *should* do: be helpful. If it turn out that intentional psychology is capable of providing services which are both desperately needed and irreplaceable, I'll be arguing, then we shall or should keep intentional psychology in business; it's that simple. Such is the case, I'll be urging – millions of people are miserable and need the help that clinical psychology can provide. However, lest we prejudge the issue, let us go on to examine and consider the evidence in more detail.

My bottom line against the eliminativists, then, shall be that, contrary to their suggestions, innuendoes, and allegations, clinical psychology does work a lot better than they might think, and furthermore, the alternatives don't work nearly so well as they would like to think, and anyway, there's plenty of work for each of the paradigms to do, so we shouldn't be trying to get rid of any of them. In short, my conclusion will be that the most likely prospect is that we will continue to use both medicine **and** psychology, and neither one will be eliminated.

Chapter 2: Philosophy of Language and its Implications for Philosophy of Language

Contents

Introduction: Narrow Psychology and its Philosophical Opposition

"Narrow" psychology is committed to explaining people's behavior solely by reference to their internal states – its explanations go no wider than the subject's own boundaries. In other words, it abides by the methodological precept known as "methodological solipsism"[21] (hereafter "MS," also known as the principles of "individualism"[22] or "autonomy"[23] which constrains individual psychology to confine its explanations of individuals' behavior to states which inhere ***within*** the individual. MS thus articulates what Putnam (1975a, p. 220) submits has long been the operative assumption of traditional philosophy and psychology: that "no psychological state, properly so called, presupposes the existence of any individual other than the subject to whom that state is ascribed" (hence its "solipsism"). According to this construal of psychological states and the accompanying injunction to advert only to factors internal to the subject whose behavior is to be explained, the ***external*** relations our intentional states might bear – such as whether our beliefs are *true*, or whether the objects of our attitudes truly *exist*, i.e., whether our categories and terms actually *refer* to real objects – are irrelevant for the purposes of explaining purposive behavior.[24] The rationale for this, as Marras (1985, p. 304) puts it, is that "cognitive behavior is necessarily a function of the way an organism *represents* the world, but not necessarily a function of the way the world *actually* is." E.g., even though "Santa Clause" doesn't refer, the belief that it does is responsible for many children attempting to be nice before Christmas; and although we act on the basis of what we *think* is true, it's not the truth or falsity of the belief *per se* which causes us to act, it is the belief itself, because truth is not a causal force;[25] and since subjects are in no position to distinguish genuine perceptions from systematic hallucinations, it makes no difference to their ensuing behavior which it is – they act on the information as they construe it, ***as if*** what they see is real.[26]

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[21] The classic sources of the term "methodological solipsism" are Putnam (1975a) and Fodor (1980). However, apparently it can also be found in Husserl's *Cartesian Meditations* (trans. 1960); I'll be considering some of Husserl's views in Section 2.5.2.2 below.

[22] The principle of "individualism" is Tyler Burge's name for MS, since it enjoins investigators to refer solely to the individual's states: see Burge (1979), Burge (1986).

[23] Stich's name for MS is the principle of "autonomy," since it treats psychological states as autonomous: see Stich (1978), Stich (1983), and Stich (1984, unpublished).

[24] *Cf.* Fodor (1987, p. 158, n. 8).

[25] Of course, just what truth <u>is</u> is hard to say – some sort of abstract correspondence relation – but it definitely doesn't seem to be an active force like gravity or electricity. We do, however, incorporate truth into several mentalistic categories which are sometimes expressed as "success" verbs or "factives," such as seeing, remembering, and knowing. However, as Marras (1985, p. 302) remarks, "knowledge, as distinct from 'mere' (firmly held) belief, contributes nothing further to the etiology of behavior," and similarly, Stich (1978, 1983) argues that these states are <u>hybrid</u> in character, in that they combine non-psychological properties such as truth with purely psychological components, and he submits that only the latter are psychologically salient. E.g., if Jones is called upon to say whether or not there is a greatest prime number,

> "...we are inclined to insist it is Jones' ***belief*** that there is no greatest prime number that plays a role in the explanation of his answering the exam question. He may, in fact, have ***known*** that there is no greatest prime number. But even if he did not know it, if, for example, the source of his information had himself only been guessing, Jones' behavior would have been unaffected. What knowledge adds to belief is psychologically irrelevant. Similarly the difference between really remembering that p and merely seeming to remember that p makes no difference to the subject's behavior." (Stich 1978, p. 574)

[26] Cf. Fodor (1981, p. 231) who explains that when we consider the mind as a kind of computer with internal representations which are causally connected to one another and to inputs and outputs, it doesn't matter to our behavior whether what appears to be sensory input from the outside is actually the product of "transducers faithfully mirroring the state of the environment, or merely [of] the output end of a typewriter manipulated by a Cartesian demon bent on

Given people's tendencies to think about, fear, and act for the sake of non-existent or imaginary objects such as gods and god-given rights, it seems especially appropriate for psychology to have a methodology which doesn't presuppose that its subjects' mental states are actually referring to anything beyond their flights of fancy. In addition, as I shall be arguing in more detail in Chapter Three, MS is an appropriate guideline for clinical psychologists, since by confining their explanations to features within the *subject's* head, it cautions investigators to neither ***over***-ascribe content,[27] nor ***under***-ascribe it;[28] instead, they should seek and report the actual content inside the subject's head.

Moreover, not only does MS comport well with the traditional philosophical and psychological understandings of both intentional states (as we are about to see in more detail in this Section) and of the object of psychological inquiry, but as Jerry Fodor (1980) and others have pointed out, it is also integral to the research program known as "Computational Psychology" (hereafter "CP"), which can provide a theoretical foundation for intentional psychology. Individualistic CP attempts to perform two services for intentional psychology: to satisfy a materialist ontology by "discharging intentional loans" (as Dennett 1978 puts it) by cashing them out in terms of physical processes such as neurally encoded symbolic processes, and also to satisfy intuitive constraints on proximate causation. If a theory is unable to sketch some sort of account of how each instance of some posited property or process could inhere in some physical property or other, it is left with what Herbert Feigl has called "nomological danglers," and open to the charge that it is either making a disreputable appeal to "spooky" stuff, or speaking nonsense.[29] However, by locating mental processes inside our brains, in an optimal position to cause our behavior, individualistic psychologists can fend off the challenge that their theories are incompatible with the physical sciences. This constraint has been formulated as a principle of ***supervenience*** (see Kim 1978): to say that narrow psychological states *supervene* on the subject's body means that they are entirely determined by the subject's underlying physiological and dispositional properties, non-intentionally described; this entails that anyone with identical physical states will have identical psychological states, and that people's psychological states can differ only if their internal physical ones do.[30] MS is thus partly a ***realizability*** constraint: the psychological states

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deceiving the machine" -- we act on them in either case. Fodor uses the example of Terry Winograd's SHRDLU program (which is instructed to manipulate blocks and pyramids) to illustrate his point: it acts ***as if*** it were manipulating real blocks, but in fact there are none -- "the machine lives in an entirely notional world; all its beliefs are false" (1981, p. 230). This idea of "notional" worlds will be figuring prominently into my discussion in defense of narrow psychology.

[27] E.g., scientists can state many things about the bearish object impinging on someone's senses in terms of elaborate zoological classifications and chemical and physical theories, but we shouldn't impute this information to a subject who simply thinks he's being chased by some great furry beast.

[28] E.g., we would be missing a good deal of explanatory power if we simply stated that Moses thought he was watching a burning bush.

[29] E.g., see Rorty (1979), Churchland (1981), and Stich (1983), who liken the posits of "folk" psychology to non-existent entities such as witches, demons, and phlogiston, and recommend that we phase them out of serious scientific discourse. I will be responding to their recommendations in Parts II and III.

[30] Cf. Patricia Kitcher (1985, p. 79), who notes, "on Kim's [1978] account [of supervenience] one type of property is supervenient on a second type if the second class of properties completely determines what the properties of the first type will be," or Quillen (1986, p. 141), who states that MS's supervenience requirement is that: "Psychology's theoretical states or properties ought to supervene on the subject's chemical, neural, behavioral, and functional histories, where these histories are specified non-intentionally and in a way that is independent of physical or social conditions outside the individual's body."

or processes we posit to explain behavior must somehow be instantiable in organic machines such as ourselves, and actually be instantiated in the subject.[31] As Fodor,[32] Stich,[33] and Dreyfus[34] have argued, the Artificial Intelligence models associated with CP have respected this constraint by employing various "scripts," "frames," "schemata," and other sorts of representational networks which are located ***within*** the computational systems instantiating them, in the form of physically encoded symbols, algorithms, and rules.

However, while all this may seem to be sound advice, the view that a subject's attitudes are constituted by his or her own states has not gone unchallenged. Prior to 1975, it was natural to assume that two of psychology's main goals – to explain subjects' behavior by detailing the internal states which are causally efficacious, and to characterize what the subjects believe and want – were compatible. Since then, philosophers have argued that these goals pull in different directions. Hilary Putnam (1973, 1975, 1983) and Tyler Burge (1979, 1986) and other philosophers of language and psychology have argued that intentional content or meaning is ***not*** in the head since it is at least partly a function of the wider links to the external environment and linguistic community, and concluded that our ordinary natural language psychological explanations are ***not*** compatible with MS. Consequently, they have submitted that something has to give. Either psychology has to foresake MS (if indeed it has been abiding by it at all, which Burge disputes) and largely abandon CP, in which case it seems once more to be in need of a theoretical foundation; or it must bifurcate into two independent disciplines: i) a scientific "sub-personal" or "sub-doxastic" psychology, which will cleave to MS by explaining behavior in terms of the computational or physiological mechanisms underlying our behavior, and ii) "Interpretation Theory," which offers semantic characterizations of what these states and mechanisms are doing. However, neither of these alternatives is desirable, in my view, since they may lead future psychologists to either inappropriately ascribe "wide" content in order to explain individuals' behavior (as I shall explain here in Part I); or, even worse, to ascribe ***no*** content at all, since they either regard what ***is*** in the head or in computers as amounting to "mere" syntax,[35] or they regard content as being irrelevant to psychology's needs (as I shall explain in Parts II and III). Accordingly, I shall now set out these developments and challenges within the philosophy of language and psychology in more detail in the next Section, in order to respond to them more adequately in the subsequent Sections and Chapters.

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[31] Cf. Patricia Kitcher (1985, p. 87), who agrees this realizability constraint is the traditional motivation of supervenience theories, and see Marras (1985, pp. 304-305).

[32] E.g., see Fodor (1980), which is reprinted in his (1981), or "Tom Swift and His Procedural Grandmother," in Fodor (1981).

[33] Again, see Stich (1978), (1983), and his unpublished (1984).

[34] In his *Husserl, Intentionality, and Cognitive Science*, Dreyfus (1982, pp. 15 ff.) points out that many of the AI models such as "scripts," "frames," "schemata," and other sorts of representational networks continue Edmund Husserl's efforts to make psychology scientific, by "bracketing" out factors external to the subject (such as whether our representations are about anything real, or how natural science would characterize the objects on the other side of our sense-organs, if they are).

[35] See Putnam (1975a), (1983); *cf*. Searle (1980), or Fodor (1981, p. 233), which remarks concerning the computa-tional program SHRDLU, "The machine doesn't know what it's talking about and doesn't care; *about* is a semantic relation."

Twentieth Century Philosophy of Language

Description Theories

To one steeped in the prevalent views in Twentieth Century Anglo-American philosophy of language prior to the mid-1970's, the supervenience constraint imposed by MS would seem quite compatible with the twin goals of individual psychology mentioned above.[36] For our purposes, the 20th century began in 1892, the year that brought Frege's brilliant paper, "On Sense and Reference," which poses a puzzle about identity statements: supposing that "a" and "b" actually refer to the same thing, why doesn't "a=b" seem as trivial and uninformative as "a=a"? For example, why does "Hesperus is Hesperus" seem less significant than "Hesperus is Phosphorus," although they have the same truth conditions? Among his many distinctions, Frege answers this question by distinguishing between the ***sense*** of expressions, and their ***referents*** or ***denota*** – the things they talk about – and he submits that two sentences may refer to identical objects and attribute identical properties to them, yet express different objective ***thought*** content, nevertheless, in virtue of the differing senses of the referring expressions.[37] The sense of "Hesperus," as we know, is roughly, "The star you see at such-and-such a place and time," but what ***is*** a "sense," exactly? A ***Sense*** (if we are to hypostatize), if it is anything, exists (or perhaps "subsists") as some sort of "ideational" item[38] bearing that intentional content; although Frege himself says very little about what a sense is, the example he does give licenses the interpretation that a sense is a set of descriptions associated with a term.[39] An expression's ***referents***, on the other hand, are usually[40] a whole different kettle of fish – they can and apparently do exist as independent physical objects in the external world (in the case of "Hesperus" and "Phosphorus," of course, the referent even *is* an external world: Venus!).

Frege's contribution was soon supplemented by another cornerstone of the classical view: Bertrand Russell's famous 1905 paper, "On Denoting." In that paper and related works,[41] Russell develops the idea that some expressions are used as abbreviations for a ***definite*** description ("the so-and-so") which picks out the unique bearer (if any) of the name, in order to explain our ability to talk about non-existent entities, without needing to violate logic's laws of the excluded middle (every proposition must be either true or false) and non-contradiction (a proposition can't be both true and false), or posit a type of unreal existence for them. E.g., for a denoting phrase such as "Apollo," which doesn't really denote anything, Russell (1956, p. 54) suggests "A proposition

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[36] I.e., to give a semantic characterization of the subject's mental states (e.g. wanting to be President) and a causal explanation for his behavior.

[37] See Frege (1892), reprinted in Martinich (1985, p. 211).

[38] Unfortunately, Frege did not hold that "senses" are ideational in the sense that they are psychological events, such as "intended meanings," or anything like that; he is, after all, the harshest critic of " *psychologism*." However, as I'll be arguing shortly, a sense-based Intentional theory need not subscribe to Frege's version of Platonism, which posits an independent realm of Ideas and necessary truths. Instead, the states Frege calls "the modes of presentation," which are psychological events and processes (such as the images associated with a word) can be adapted to the purposes narrow psychology needs.

[39] In note 4 (in Martinich 1985 p. 212), Frege notes that the sense of "Aristotle" might be taken to be "the pupil of Plato and teacher of Alexander the Great," allowing that opinions about the sense may differ.

[40] Referents are *usually* physical objects or events, but not always, if the Platonists are right that some referents apparently *are* Ideas, Senses, or Numbers, etc.; but even they grant that we can't see how on Earth that could be so.

[41] E.g., see Russell (1956), or his "Descriptions," from *Introduction to Mathematical Philosophy*, reprinted in Martinich (1985).

about Apollo means what we get by substituting what the classical dictionary tells us is meant by Apollo, say 'the sun-god'." And if it's not the case that there is exactly one individual which has the attributes in question, then according to Russell's theory of descriptions, phrases such as "The round square" and "The present King of France" don't refer to ***anything***, much less unreal individuals. This successfully blocks the apparent violation of the law of contradiction, because it denies that sentences like "The round square is square," and "The round square isn't square (since it's round)," are ***both*** true, and it also preserves bivalence, because the sentences which attribute properties to non-entities aren't devoid of a truth-value – they are **false**, since they assert that something exists (e.g., a bald King of France), whereas in fact there is no such thing. Such sentences certainly aren't nonsense or senseless, on Russell's view, since although their putative subject doesn't exist, it can be analyzed in terms of a meaningful description.

This sense/reference distinction and the description theory which accompanies it has since been widely adopted by the Intentional tradition, but sometimes under a different description. For instance, following C. I. Lewis,[42] Irving Copi's standard ***Introduction to Logic*** texts continue to distinguish between the ***extension*** or denotation of a term and its ***intension*** or connotation: "The objective connotation or objective intension of a term is the total set of characteristics common to all the objects that make up that term's extension;"[43] e.g., the extension of "skyscraper" is {the Empire State Building, the Sears Tower, ...}, while its intension is a description of skyscrapers' individuating features, such as "An office building over 15 stories tall (?)." In time, however, many philosophers recognized (even as Frege had in his note on Aristotle cited above) that different people associate different senses with the same term, yet still manage to make reference to the same individual (e.g. the description "the teacher of Alexander the Great who was born in Stagira," picks out Aristotle, yet makes no mention of Plato), so they began to relax the theory somewhat from the more idealized version which associates one objective sense with each term. In particular, in his 1958 paper "Proper Names," John Searle presents an alternative to the strict Russellian view. First, he agrees with Peter Strawson[44] that sentences such as "This is Aristotle" do not actually *assert* or specify that an individual with some set of characteristics is present; rather, the user of the name ***presupposes*** certain things about the bearer of the name. More importantly for the purposes of psychology (which is not particularly interested in whether "The present King of France is bald," is true, false, or neither), Searle (1958, p. 273) argues that names are "pegs on which to hang descriptions," and that referring uses of them presuppose that some significant subset of them actually apply, but it is not necessary that ***all*** the descriptions be true or known by competent users. Thus, two speakers could generate different backing descriptions for an expression, yet still be talking about the same thing. But the critical point for the purposes of individual psychology is that when subjects use a name or referring expression, they must have a "*cognitive fix* on it ... something in one's thought [which] can correctly distinguish the referent from everything else in the universe," as Wettstein (forthcoming, p. 2) puts it – some sort of internalized description or theory by which to pick out or identify the object of belief. Similarly, as Strawson remarks,[45] "it is no good using a name for a particular unless one knows who or what is referred to by the use of the name. A name is worthless without a backing of descriptions which can be produced on demand to explain the application."

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[42] See C.I. Lewis, "The Modes of Meaning," *Philosophy and Phenomenological Research'*, 4, 1944.

[43] I. Copi, *Introduction to Logic*, Sixth Edition (New York: Macmillan, 1982, p. 155).

[44] See Peter Strawson's 1956 paper, "On Referring," reprinted in Martinich (1985).

[45] From Strawson's Individuals' (1959, p. 20), quoted in Martinich (1984, p. 183).

At first, pointing out that what a word means is one thing, and what it designates or names is another, seemed to give everybody what they wanted: there can be a real external world that we're talking about, all right, but there can also be meaning even in our material world – ***if*** we were capable of somehow "grasping" these "Senses" (as Frege put it) to make our signs significant. However, so far as the 'hard-core' materialist critics have been concerned, such "grasping" after Meaning only amounts to straws, unless there could be some way of actually carrying it out. And while most intensional theorists supposed that our brains are somehow or other capable of such understanding, they were unable to satisfy this basic metaphysical challenge on the part of the growing number of physicalists and behaviorists who thought that such an appeal to inner cognition was disreputable and unverifiable. As if this were not enough, the materialist chorus challenging intentional realists to explain how brains could possibly be capable of truly thinking has frequently been accompanied by the complaints of *dualists*, *anti-realists*, and *instrumentalists*, as well. From Descartes (in the 17th Century) through Franz Brentano (early in the 20th Century) right on up to Saul Kripke (in the 1970's and 80's), analytically inclined and seemingly logical philosophers have argued that physical things can't really think, because physical things and mental things ***necessarily*** fall into distinctive categories (see Brentano 1960; Kripke 1972/1980, 1977a; Schwartz 1977).

With these criticisms, prospects didn't look too good for intentional psychology, at least in academic psychology. With the advent of the computer age, however (which, somewhat ironically, given his opposition to "psychologistic" approaches such as the one being represented, was probably greatly hastened along as a direct result of Frege's pioneering efforts in symbolic logic), things changed. As increasingly sophisticated and very physical symbol processors were developed, and more and more people began to accept that we are literally "organic computers," the phrase "mind-brain" seemed less of an oxymoron and more of a redundancy as time went on. The insights of Computational Theory, which blends causality with symbolism, seemed to provide the solution to the metaphysical puzzles at last. Computers can, after all, not only grasp symbols, but also process, manipulate, calculate, and compute with them, so maybe our brains are capable of making sense after all, since the Senses we understand might just amount to symbolically encoded *definitions* and *descriptions* which are associated with the expressions, as those in the Fregean tradition from Russell (1919) to Searle (1958, 1983) have alleged. Thus, we seem to have come to our happy resting place – a philosophically defensible account of narrow, meaningful states – in one fell swoop: meaningful thinking can be carried out via the manipulation of things such as sentences in our computational brains.

That, at least, was the position of influential M.I.T. works such as Fodor's 1975 classic, ***The Language of Thought***. Thus, despite the continuing protests of critics such as Herbert Dreyfus (the author of 1972's ***Why Computer's Can't Think***) and even Searle himself (who argues in his [1980] roughly that computers 'don't have what it takes' to really be able to interpret symbols) to the contrary, many in what is now called the cognitive science community came to believe that computers had managed to solve the philosophical problems such as "Brentano's Problem" and the "mind/body problem," along with their many other accomplishments. This by now familiar successor to the clockwork model of the mind came to be known as ***functionalism*** in the late 1960's, in accordance with its view that cognition is the result of the systematic functioning of complex systems, however they happen to be composed. Its articulation culminated in Fodor's

"Representational Theory of the Mind" or "RTM" (see Fodor 1981), which was intended to breach the gap between the physical and the mental once and for all, with its claim that propositional attitudes are actually ***computational*** states, i.e., processes or states bearing semantic relations to one another and to the world that are organized in such a way as to be capable of respecting logical relations such as entailment. (They show their respect by executing logical operations.) Moreover, as Fodor (1980) observed, the computational story's emphasis upon *internal* symbols and representations has an added twist: ironically, for a theory comporting with materialism, it has the virtue of preserving the basic Cartesian intuition that intelligent behavior can be explained by mentalism, by an appeal to the *subject's* conceptions of what is going on – however chimerical or illusory they may be – to account for purposive behavior.

Thus, by the mid-seventies, the situation in the mainstream Anglo-American philosophies of language, mind, and psychology, seemed to be following: the mind-body problem was solved or dissolved by the claim that our minds are organic computers; "folk" psychological explanations had integrity after all – we really do act be***cause*** of our attitudes, which are chugging away in our brains; and so we had a philosophically defensible explanatory paradigm for behavior to serve as an alternative to the strictly physicalist and behavioral ones which had been emerging.

However, philosophical challenges aren't easily put to rest, and they have a nasty habit of reappearing, so more troubles soon loomed for the view of the intentional realist that our psychological states are actually just a certain type of complex processing in our brains. Some of these more recent challenges have been put forward by some of the very founders of the functionalist position, such as Hilary Putnam, who has joined others in arguing that computational psychology is unable to realize both of the goals it seeks to attain. To see why, we should turn now to the development of to so-called causal theories of reference.

Arguments Against the Description Theory

Description theories of reference have been challenged on three fronts by leading exponents of an alternative theory for how words and sentences refer to things in the world – the causal or historical chain theory. Keith Donnellan argues that subjects can refer to things despite having patently mistaken descriptions of them; Saul Kripke maintains that identifying descriptions are neither necessary nor sufficient for reference; and, most significantly for the project of intentional psychology, Hilary Putnam argues that the descriptions in the head are not sufficient to fix the content of the attitude or assertion, even when they are plentiful and accurate. This subsection will discuss Kripke and Donnellan's challenges and sketch the causal theory of reference, and the next will present Putnam's argument.

Donnellan and Kripke's Arguments

Donnellan's work[46] distinguishes two uses of definite descriptions: attributive and referential. When descriptions are used attributively, the intent is to refer to whatever fits the description or has the attributes in question, if indeed any such thing exists (e.g., "The omnipotent creator is just"). In the referential use, however, the description's applicability is defeasible: its function is just to draw the listener's attention to whatever the speaker has in mind, but may be describing inaccurately. E.g., some courtroom observers might remark, "Smith's murderer is insane," thereby referring to the defendant in the dock – who may in fact be innocent of the crime. As Donnellan (1985, p. 238) puts it, "In the attributive use, the attribute of being the so-and-so is all important, while it is not in the referential use." In the referential use, pointing to the object or giving it some other name or description would have accomplished the same objective just as well: "the defendant," "the man I'm looking at," "the big guy over there," etc.

Donnellan's distinction in itself is not particularly harmful to individualistic psychology. While it does show that the literal sense of the descriptions speakers utter do not always correctly determine reference, it does not threaten the view that speakers can only refer to or think about things by having some sort of "cognitive fix" (as Wettstein [forthcoming] puts it) on them. The point is, the courtroom observers *thought* the defendant was a murderer, which is why their description refers to him, and their (erroneous) description itself is backed by a variety of *sensory* information, such as the appearance of the alleged murderer. However, examples such as Donnellan's did plant a considerable seed of doubt in the view that subjects have to know what they are talking about – a seed which was fertilized by the so-called "New Theory of Reference" or the Causal/Historical view developed by Kripke and others.

Kripke's seminal ***Naming and Necessity*** lectures[47] also develop the idea that competent language users may have mistaken views about the things they refer to. Kripke argues that a set of descriptions which constitute identifying knowledge with which to pick out the referent from everything else is neither necessary nor sufficient for achieving reference when a certain type of denoting phrase is used, the type he calls a ***rigid designator***.

The distinguishing feature of rigid designators is that they refer to the same object in every possible world or across counter-factual situations, even where some or all of the non-essential attributes of the thing change (Kripke 1980, pp. 48-49). ***Names*** are rigid designators, for, in a sentence such as "Nixon might have lost the '68 election, or he might have never gone into politics at all," the name "Nixon" refers to the man who did in fact become President, but who might not have had things been different. Names thus differ from "non-rigid" designators which, by keeping the descriptive content fixed rather than the object, might pick out *different* individuals when the facts vary; e.g. as it happens, "the inventor of bifocals" refers to Ben Franklin, but had Franklin been less industrious or keener in vision, the phrase would single out whoever had invented them in his stead. This difference is crucial, Kripke argues, since it establishes that a name is not *synonymous* with some set of descriptions, that descriptions do not give the *meaning* of names but at best are used to "fix the reference," and that names can be used

[46] See Donnellan's "Reference and Definite Descriptions," 1966, reprinted in Martinich (1985), and "Proper Names and Identifying Descriptions," *Synthese*, 21, 1970

[47] Kripke's *Naming and Necessity* lectures were delivered in 1970, printed in 1972, and reprinted with notes and an introduction in Kripke (1980).

to refer without or even in spite of the descriptions which a speaker might offer to explain or support his usage.

Kripke argues on intuitive grounds that names are not synonymous with even some cluster of descriptions. As we saw above, the merit of Searle's theory of proper names is that a cluster of descriptions allows for some slippage and error, unlike the stricter Russellian view. On the definite description view, if "Aristotle" is an abbreviation for the description "The best student of Plato, ... and the teacher of Alexander," but it turns out that it was Thrasymachus who taught Alexander, then "Aristotle" would not refer (since no one was *both* the famous student and teacher), but on the cluster view, so long as most[48] of the description applies, the name still refers to Aristotle. Moreover, the cluster theory avoids the unwelcome consequence that it is as ***necessary*** that Aristotle is the teacher of Alexander as it is that a bachelor is unmarried, by maintaining that "Aristotle" implicates a disjunctive series of attributes (e.g., Plato's best student, and/or the author of ***Metaphysics***, and/or Alexander the Great's tutor, and/or...) without *entailing* that any particular one applies. However, as Searle (1958, p. 274) notes, even the cluster view entails some necessity: "it is a necessary fact that Aristotle has the logical sum, inclusive disjunction, of properties commonly attributed to him." Kripke (1980, pp. 61-63) argues that clearly this view is false, since

> Most of the things commonly attributed to Aristotle are things that Aristotle might not have done at all. ... Not only is it true ***of*** the man Aristotle that he might not have gone into pedagogy ... but the possession of the entire disjunction of [his] most famous achievements is just a contingent fact about Aristotle; and the statement that Aristotle had this disjunction of properties is a contingent truth.

Here Kripke expresses both the metaphysical belief that it is a contingent matter of fact what characteristics and life-events an individual has (rather than a matter of definition[49]) as well as a socio-linguistic theory about how names are used: rigidly. This theory involves the rejection of the thesis that names have a sense or connotation on the grounds that they are not ***synonymous*** with any description, since it is not contradictory to deny that the person named had the attributes commonly ascribed to him.[50] Kripke (1980, pp. 134-35) also maintains that certain general terms, natural kind terms such as "gold," "tiger," "heat," "light," and even adjectives such as "red" are rigid designators, hence they too have no connotation.

However, Kripke does not claim that descriptions are ***irrelevant*** to names; he acknowledges that they are sometimes used to fix the reference. Just as Donnellan's courtroom observer uses the description "Smith's murderer" to pick out the defendant (i.e. to fix the reference of the phrase), someone might say "the greatest man who studied with Plato" to fix the reference of "Aristotle." In the former case, pointing and saying "that man" would perform the reference-fixing function just as well; in the latter, some description is needed to introduce the long departed philosopher to the audience, but the description does not ***define*** "Aristotle," it just picks out Aristotle (Kripke 1980, 57). But Kripke ***does*** deny that the descriptions associated with a rigid designator which

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[48] A *weighted'* most – some descriptive factors may count more heavily than others. E.g., despite the discovery that they're not giant *fish*, we still think there are whales.

[49] *Pace'* Leibniz, who agrees that it is contingent, but holds that it is *certain'* that all the predicates which are true of him are included in the 'complete concept' of an individual. See "Discourse on Metaphysics," Par. 13. It is interesting to note that Russell's first book (1900) is *A Critical Exposition of The Philosophy of Leibniz.*

[50] See Kripke (1980, p. 61), and his "Identity and Necessity," in Schwartz (1977, pp. 93-94).

are in fact used to fix reference ***must*** apply if the name refers: maybe Aristotle didn't do any of the things we think he did; probably Jonah wasn't swallowed by a big fish, but "Jonah" still refers to the real prophet (1980, p. 67); and the reference of "Phosphorus" is fixed by "the morning star," which, as it turns out, is not a star but a planet (n. 34, p. 80).

Finally, Kripke's views taken together deal a serious blow to the classical description theory, since he maintains that identifying knowledge is often neither necessary nor sufficient for reference. He argues that identifying descriptions aren't necessary, because often we lack a backing description which would pick out some unique individual (e.g. when we say "Feynman" knowing only that he is a famous physicist), yet we refer (to Feynman, even though our description cannot single him out from, say, Gell-Mann: p. 81). Nor are they sufficient for fixing the reference (i.e., it is not the case that the referent of the phrase is always the thing that matches the description): suppose that most speakers can only back their usage of "Columbus" by saying, "He discovered America," but suppose also that in fact some Norseman discovered it years earlier; if the description theory is correct in asserting that reference is determined by sense, then we are referring to the Norseman when we say "Columbus," but, Kripke (1980, p. 85) maintains, "This seems simply to be false." If we refer to Columbus, nevertheless, something *other* than our backing description of the name must be determining the reference.

But what would that be? As we'll now see, Donnellan, Kripke, and Putnam go on to present an alternative account of how words connect to the world, one which does not exclusively rely upon descriptions as intermediaries – the causal theory of reference.

Causal or Historical Theories of Reference

In order to account for our apparent ability to refer to historical and public figures we know little or nothing about, Kripke, Donnellan, Putnam, Michael Devitt (1984), and Gareth Evans,[51] among others, have advanced the Causal or Historical Chain theory of reference for names and other rigid designators, which minimizes the amount of specifying knowledge which is required of the competent language user. This alternative account of how names hook up to their referents which does ***not*** require speakers to know enough about the referent to be able to distinguish it from everything else, is sketched here by Kripke (1980, pp. 91, 95):

> ... a baby is born; his parents call him by a certain name. They talk about him to their friends, Other people meet him. Through various sorts of talk the name is spread from link to link as if by a chain. A speaker who is on the far end of the chain, who has heard about, say Richard Feynman, in the marketplace or elsewhere, may be referring to Richard Feynman even though he can't remember from where he first heard of Feynman or from whom. ...In general our reference depends not just on what we think ourselves, but on other people in the community, the history of how the name reached one, and things like that. It is by following such a history that one gets to the reference. This is a very intuitive sort of picture. A speaker in the presence of a person or object performs a naming ceremony: he sees the object, points to it, baptizes or christens it, and utters the name to others; when his audience subsequently utters the name, they refer to the object in virtue of these links.

[51] See Gareth Evans' "The Causal Theory of Names," 1973, reprinted in Schwartz (1977), and Martinich (1985).

These are physical processes – causal processes. Sometimes, of course, the chain is quite convoluted, e.g. for Biblical figures whose names have been transliterated several times;[52] sometimes the chain is broken and the name takes on a different reference.[53] Moreover, subsequent utterances of names count as referring uses only if the speaker is linguistically competent – parrots may talk, but they don't refer – so the theory owes some sort of account of what competence amounts to; I'll be returning to the significance of this point later in this Chapter.

Nonetheless, putting such wrinkles and niceties aside for now, Kripke's sketch of the theory both allows for and provides an explanation of our ability to refer to things we know next to nothing about by adverting to the causal chain in virtue of which we "borrow" reference from those who were in perceptual contact with the person or object. If it is primarily the act of borrowing plus the external historical links to the referent which determines the content, rather than the subject's internal description of the referent, then it would seem that the intensionalist picture is misguided, at least with respect to names. As we'll now see, similar arguments have been advanced against the descriptivists' account of kind terms, as well.

Putnam and Twin Earth

In a series of works, Putnam has taken up Kripke's (1980, p. 128) example of "fool's water" (a substance which resembles water's phenomenal properties, but has a different atomic structure) to apply the causal theory of reference to natural kind terms, and develop a sustained critique of both description theories and the individualistic assumption that the contents of mental states supervene on the subject's physiology. As we'll see, the startling conclusion of this famous "Twin Earth" argument is that meaning is not in the head.

The first step of the argument fleshes out Kripke's account of a referential baptism. Putnam is explicit about the fact that the christening or grounding of a natural kind term such as "water" depends upon the referential ***intentions*** of the grounder of the term. Putnam maintains that our language functions such that we both presuppose that there *are* kinds, and intend to refer to them. The crucial premise in his argument is that we must ***intend*** to use the kind term to apply to "stuff of the same kind," and not to anything merely superficially equivalent to whatever is ostended:

> I point to a glass of water and say "this liquid is called water" ... the necessary and sufficient condition for being water is bearing the relation *sameL* to the stuff in the glass .... The key point is that the relation *sameL* is a *theoretical* relation: whether something is or is not the same liquid as *this* may take an indeterminate amount of scientific investigation to determine.
> (Putnam 1983, p. 122)

> It has long been our *intention* that a liquid should *count* as "water" only if it has the same composition as the paradigm examples ... this was our intention even before we *knew* the ultimate composition of water ... *given those referential intentions*, it was always impossible for a liquid other than H2O to be

[52] Since written Hebrew has no vowels, the Greek, Latin, and then English translations had to supply them, perhaps losing the original forms in the process.

[53] E.g., "Madagascar" is a corrupted form of a name denoting a part of the African mainland, but has come to denote the island, after Marco Polo's misunderstanding (see Evans, in Schwartz 1977, p. 203).

> water, even if it took empirical investigation to find it out.
> (Putnam 1982, p. 157)

This view is sometimes known as "essentialism," because the kind term or name is thus intended to refer ***rigidly*** to the essential nature of the kind of object or stuff, e.g., to H2O.[54] According to this picture, the original grounder of the expression is in causal (i.e., perceptual) contact with the object (or stuff), which he points to and names, and then he passes the name on to others by verbalizing it or writing it down. Subsequent members of the linguistic community in the historical chain from the initial baptism are able to refer to the object, or objects of its kind, in virtue of this chain. Of course, it may take scientific experts hundreds of years to be able to reliably identify samples of it, or to uncover what the distinguishing hidden molecular structures of the natural kind actually are, but the rest of us are nevertheless able to successfully refer to things like elm trees and gold, despite the fact that we lack the knowledge to reliably individuate them.

The next stage of the argument has us imagine a planet indistinguishable from ours (hence ***Twin*** Earth), but for the fact that the liquid which flows in its rivers and lakes and bathtubs has the chemical composition XYZ, not H2O. Twin Earth is populated by molecule-for-molecule replicas (except that they are 70% XYZ, instead of H2O) of ourselves; these inhabitants also speak a language sounding just like English, and refer to the stuff they wash in as "water." However, according to the traditional view that "the meaning of a term determines its extension (in the sense that sameness of intension entails sameness of extension)" (Putnam 1973, p. 120), it follows that "water" has *different* meanings on the two planets. Since natural kind terms are ***rigid*** (in that they refer to 'the-same-stuff-as') and since XYZ and H2O are *not* the same kind of stuff, "water" has two meanings: on Earth its extension is all the H2O molecules, while on Twin Earth the extension is entirely different, *viz*. the set of XYZ molecules (p. 121).

Now comes the final stage. Roll the clock back to 1750, before either planet developed a chemistry to identify the composition of either water or twin-water. Take a competent English speaking Earthling, Oscar1, and his *Doppelganger* from Twin Earth, Oscar2,[55] and a surprising consequence results. Since "water" has a different extension on the two planets, yet Oscar1 and Oscar2 are in the same psychological state inasmuch as they have "the same verbalized thoughts ... the same sense data, the same dispositions, etc." (p. 124), Putnam (1973, pp. 122, 124) draws the conclusion:

> Thus the extension of the term 'water' (and, in fact, its "meaning" in the intuitive preanalytical usage of that term) is *not* a function of the psychological state of the speaker by itself....It is absurd to think *his* psychological state is one bit different from mine: yet he "means" *twin-water* when he says "water", and *I* "mean" water' when I say "water". Cut the pie any way you like, "meanings" just ain't in the head!

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[54] See Putnam (1975a, p. 238), and Putnam (1973, pp. 128-132).

[55] Putnam (1973, pp. 121-122) notes, "You may suppose that there is no belief that Oscar1 has about water that Oscar2 did not have about "water"...you may even suppose that Oscar1 and Oscar2 were exact duplicates in appearance, feelings, thoughts, interior monologue, etc." Burge, however, disputes the claim that the doppelgangers do have the same thoughts, given the differences in their contexts, for according to his arguments we'll be seeing immediately following in the text, he holds that the twins don't have the same 'water' concepts or thoughts; see Burge (1979, p. 117, n. 2), and Burge (1982, esp. p. 102).

Putnam's Twin Earth argument is damaging to intentional psychology for two reasons. The first is a challenge to the project of ***reducing*** thought contents (e.g., thinking that water is in the glass) to brain states, and the second is the claim that the factors in the head (sense data, internal descriptions and "monologue," etc.) are ***not*** sufficient to establish ***what*** the subject is thinking about'. If it is true that "meanings aren't in the head," Putnam (1983) argues in his "Computational Psychology and Interpretation Theory," then psychology must become bifurcated into "Interpretation Theory" and functionalist or Computational Psychology. The former is the familiar "folk" psychological practice of providing a rational reconstruction of someone's behavior by attributing beliefs and desires and interpreting what he is thinking about, but "It is as holistic and interest relative as all interpretation" (p. 154). The latter specifies the rules of computation, perhaps by postulating a formalized language of thought, but the states it talks about are not genuinely meaningful states: "there may be *sentence-analogs* and *predicate-analogs* in the brain, but not concepts" (p. 154).

Before I respond to these Twin Earth objections, I shall now present yet another criticism of the view that the contents of one's thought is determined by what is in the head. As we've just seen, Putnam and Kripke have argued that reference is determined primarily by causal links to the world, but as we'll now see, Tyler Burge has compounded the problem by emphasizing the role of ***society*** in grounding meaning.

Burge Against Individualism

One aspect of Putnam's doctrine which I haven't yet emphasized is known as "the division of linguistic labour," which draws attention to the fact that experts are sometimes called upon to "ground" the usage of laymen, who may have trouble distinguishing genuine gold from fool's gold, e.g., yet manage to refer to gold nonetheless, despite their lack of identifying knowledge.[56] The significance of this doctrine for psychology has been brought sharply into focus by Tyler Burge, who has extended the insights of the causal theory of reference in two ways, and forged them into a sustained attack upon the narrow approach to cognition, which he calls "Individualism." While Putnam and Kripke confine their remarks to speakers being able to **refer** to individuals and natural kinds, despite having an incomplete or erroneous understanding of them, Burge (1979, esp. pp. 77-84) submits that similar arguments apply to a much wider range of things – colors, diseases, sofas, movements, brisket, mortgages, contracts, recessions, sonatas, pre-amplifiers, and even things gothic – and he argues that they involve not only our ability to *refer* to things, but also our ability to *think* about them. E.g., Burge (1979, p. 81) remarks, "A fairly common mistake among lawyers' clients is to think that one cannot have a contract with someone unless there has been a written agreement." I'll begin here by setting out Burge's arguments from his 1979 paper, and then review the more direct challenges he makes against narrow psychology in 1986.

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[56] The "division of linguistic labor" is discussed in a number externalist works, such as Putnam (1983, pp. 125-26), Putnam (1975a, pp. 227-28), and Devitt and Sterelny (1987, pp. 53, 71), and it enables the speaker to discourse about things he knows little to nothing about, since he can always appeal to the experts to back his usage. Here Putnam (1973, p. 126) spells it out in terms of a sociolinguistic hypothesis – the:

> "HYPOTHESIS OF THE UNIVERSALITY OF THE DIVISION OF LINGUISTIC LABOR: Every linguistic community ... possesses at least some terms whose associated "criteria" are known only to a subset of the speakers who acquire the terms, and whose use by the other speakers depends upon a structured cooperation between them and the speakers in the relevant subsets."

Individualism and the Mental

In his "Individualism and the Mental," Burge (1979, p. 73) begins by contrasting Individualism, whose "spotlight is on what exists or transpires 'in' the individual – his secret cogitations, his innate cognitive structures, his private perceptions and introspections, his grasping of ideas, concepts, or forms," with a more social approach, such as "the Hegelian preoccupation with the role of social institutions in shaping the individual and the content of his thought...many of Wittgenstein's remarks on representation...[and] more recent work on the theory of reference." He rightly points out that individualism, as represented by people such as Plato, Descartes, and Russell,

> ...see[s] a person's intentional mental phenomena ultimately and purely in terms of what happens to the person, what occurs within him, and how he responds to his physical environment, without any essential reference to the social context in which he or the interpreter of his mental phenomena are situated....The model...suggests that what a person thinks depends on the what occurs or 'appears' within his mind...on the power and extent of his comprehension and on his internal dispositions toward the comprehended contents. (p. 103)

Against this traditional picture, Burge presents a thought experiment purporting to show that "a person's thought *content* is not fixed by what goes on in him, or by what is accessible to him simply by careful reflection...because much mentalistic attribution does not presuppose that the subject has fully mastered the content of his thought" (pp. 104-105).

Burge's view, like Putnam's, is thus that the interpretation of the content of a subject's mental states is a project distinct from providing a causal and dispositional account by appeal to "sub-personal" computational states (see note 8, p. 118). In his opinion, although the latter may be confined purely to the individual's causal and functional history, the former is at least partly determined by the linguistic conventions of the society in which the individual is enmeshed. To support this claim, he offers a three-step thought experiment, which might be called "the counterfactual society" argument, which proceeds as follows.

To begin with, Burge (1979, p. 77) has us imagine a subject with a certain conception of and standard attitudes about arthritis: "he thinks (correctly) that he has had arthritis for years, that this arthritis in his wrists and fingers is more painful than his arthritis in his ankles, that it is better to have arthritis than cancer of the liver, that stiffening joints is a symptom of arthritis." As an added wrinkle, however, he comes to the point where "he thinks falsely that he has developed arthritis in the thigh" (77). The patient complains to his doctor, who clears up his misconception by informing him that arthritis is strictly an inflammation of the joints, and that "arthritis" thus does not apply to aches in the long bones; the patient "is surprised, but relinquishes his view and goes on to ask what might be wrong with his thigh" (p. 77). In the second step of the experiment, this simple case of a mistaken belief is contrasted with "a counterfactual supposition":

> We are to conceive of a situation in which the patient proceeds from birth through the same course of physical events that he actually does, right to and including the time at which he first reports his fear to his doctor ... [with] the same internal physical occurrences ... [and] behavior....the patient's non-intentional, phenomenal experience is the same...the same pains, visual fields, images, and internal verbal rehearsals. The *counterfactuality* in the supposition touches only the patient's social environment. ...[In] our imagined case, physicians, lexicographers, and informed laymen apply

> 'arthritis' not only to arthritis but to various other rheumatoid ailments. The standard use of the term is to be conceived to encompass the patient's actual misuse. (pp. 77-78)

The counterfactual use of "arthritis" is not extensionally equivalent, so it has different truth conditions: the first patient's statement ("I have arthritis in my thigh") is false, while the counterfactual patient's is true. Burge now proceeds to the third and final step, in which he claims that the second patient actually has no *arthritis* thoughts:

> In the counterfactual situation, the patient lacks some – probably *all* – of the attitudes commonly attributed with content clauses containing 'arthritis' in oblique occurrence. He lacks the occurrent thoughts or beliefs that he has arthritis in the thigh....It is hard to see how the patient could have picked up the notion of arthritis. The word 'arthritis' in the counterfactual community does not mean *arthritis*. It does not apply only to inflammation of the joints. We suppose that no other word in the patient's repertoire means *arthritis*.... However we describe the patient's attitude in the counterfactual situation, it will not be with a term or phrase extensionally equivalent with 'arthritis'. So the patient's counterfactual attitude contents differ from his actual ones. (pp. 78-79)

Burge is quite explicit about what this is supposed to show: the subject's physical, phenomenal, and dispositional states can be held constant, while the contents of his propositional attitudes would differ (p. 79), so individualism, which holds that only the internal states are relevant to fixing content, is false. Burge maintains that the argument will go through for all the sorts of terms listed above. His point can perhaps be reduced to a formula: *what* you think doesn't depend merely on *how* you are thinking it, but also on *where*.

Of course, there are exceptions: Burge's examples, like Kripke's, allow for some misconceptions about and merely partial understandings of the true characteristics of the objects referred to, but when there is a ***total*** misunderstanding, he is reluctant to take the subject's words at face value.[57] However, in the majority of cases, Burge's (1979, p. 87) view is thus that "Social context infects even the distinctively mental features of mentalistic attributions. No man's intentional mental phenomena are insular." Nor does he rest his case against narrow psychology at this point; in addition to arguing that normal propositional attitude ascriptions are wide, rather than narrow, since they differ as a function of the subject's linguistic context, Burge also argues that narrow psychologists are fundamentally begging the question when they submit that *doppelgangers* do have the same psychology in any interesting sense.

Individualism and Psychology: Does Narrow Psychology Beg the Question?

As we've seen, Putnam and Burge grant that the *doppelgangers* have the same internal images, sensations, and representational structures, as well as identical dispositions, since they utter the same sounds when receiving equivalent stimulation, and exhibit similar motions (as when they asks and reach for aspirin upon feeling the pain in their thighs). Despite these similarities, they maintain, the content of their psycholgical states differs, due to their differing linguistic and

[57] In his example of a *total* misunderstanding, Burge (1979, pp. 90-91) writes, "If a generally competent and reasonable speaker thinks that 'orangutan' applies to a fruit drink, we would be reluctant, and it would be unquestionably misleading, to take his words as revealing that he thinks he has been drinking orangutans for breakfast for the last few weeks."

environmental contexts, and hence MS and supervenience are mistaken in supposing that psychological states differ only if the current internal physical states do.

At this point, however, the defender of narrow psychology can submit on the basis of a combination of arguments that Twin Earth cases argue for a distinction where there is no noticeable difference. First, there is a variant of what Stich (1983, pp. 165-69) calls the "replacement argument": if one of the Oscar *doppelgangers* were to be 'beamed onto' the other planet without his knowledge to replace his twin, neither he nor anyone else would be able to discern that he *was* different, or that he actually spoke a different language (*ex hypothesi*); given equivalent stimuli, the Oscars would do all the same things, such as utter "Bring water!" when thirsty.[58] Thus, it would seem that the twins have identical behaviors, and insofar as psychology is in the business of explaining behavior, they should be counted as psychological twins, as well. To maintain otherwise seems to be multiplying psychological posits beyond necessity, since as Block (1986, e.g., p. 668) and Fodor (1987, 34-35, 39-40) put it, the *doppelgangers'* identical physiologies confer identical *causal powers* upon them, and in the absence of physiological differences there seems to be no *mechanism* to account for the psychological differences the non-individualists may want to attribute.[59]

However, as Fodor (1987, pp. 36-37) himself acknowledges, critics of narrow psychology cannot be satisfied so easily. A Burgean can perfectly well grant that *doppelgangers* or clones would perform the same bodily movements in the same contexts, yet maintain that this hardly settles the psychological question. After all, two subjects can do the same thing for *different* reasons: one person might take aspirin because he thinks he has arthritis, while another may take it for a headache. It certainly is not contradictory to say that subjects could have the same causal powers, yet differ in psychology, since by coincidence they might perform similar actions for different reasons. Burge (1986, p. 11) himself levels this charge that Fodor is begging the question when he says that the doppelgnagers have the same causal powers, since

> ...it is not to be assumed that the protagonists are behaviorally identical in the thought experiments. I believe that the only clear, general interpretation of 'behavior' that is available and that would verify the first premise [that they have the same behavior is 'bodily motion']. But this construal has almost no relevance to psychology as it is actually practiced....Much behavior is intentional action; many action-specifications are non-individualistic.

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[58] Of course, they would have different de re attitudes when they are embedded in different contexts, in that one will be referring to H2O-stuff, while the other's attitudes will be directed at XYZ, without his realizing it, but de re' attitudes are beside the point, according to both sides of this dispute (e.g., see Burge 1982). I will be returning to the matter of de re' attitudes in Section 2.4.2 below.

[59] As Fodor (1987, pp. 39-41) argues, doppelgangers have the same psychology because there is apparently no mechanism available to explain how they could have different causal powers, since they have the same physiology and "... *you can't* affect the causal powers of a person's mental states without affecting his physiology. That's not a conceptual claim or a metaphysical claim, of course. It's a contingent fact about how God made the world. God made the world such that the mechanisms by which environmental variables affect organic behavior run via their effects on the organism's nervous system. Or so, at least, all the physiologists I know assure me." (pp. 39-40) Not unreasonably, Fodor (1987, p. 40) (and Ned Block, whom he credits for the argument) resist Burge's claim that linguistic affiliation or membership in a linguistic community can determine psychological states, since (unlike genetic endowment or early training, e.g.) it does not seem to be the right sort of thing to act as a mediating causal mechanism in food preference, e.g., since it has no differentiating effect on the twins' physiology, and we expect psychological differences to be reflected in physical ones.

On a wide construal, the Twins do **not** actually behave the same way: while the Earthling Oscar complains of arthritis and orders a glass of water, the Twin-Earthling Oscar2 complains about his case of 'twarthritis' and orders 'twater' or XYZ.

This seems to leave the defender of MS or supervenience with little or no room to move: either he is merely ***stipulating*** that identical physiologies confer identical narrow psychologies, which is uninteresting; or he is attempting to argue to the sameness of the internal psychology via the external effects, but that route seems to be blocked, since the Twins apparently do not perform the same behaviors. Unless or until the narrow psychologist can tell us ***why*** they behave so – or even say what it is they are both doing – why should we think that their movements should be explained the same way, or that they are acting for the same reason? Thus, the narrow psychologist is begging the question if he thinks that it's enough to show that *doppelgangers* have the same causal powers; to convince his critics that sameness of causal powers indicates sameness of psychology, he must assure them without question begging that they perform the same movements *because* they have the same psychology.

The natural bridge for connecting subjects' internal psychology with their externally manifested "causal power" behavior would be to speak of their *intended* behavior: perhaps the Twins perform the same movements because they had identical conceptions of what they were doing, and identical intentions to behave. Of course, on Burge's wide content analysis, they not only have different concepts and behavioral intentions, but also different ensuing behaviors, as we've just seen, so the onus seems to be on the narrow psychologist to say just what narrow concepts, intentions, and hence intended behavior or actions the Twins hold in common. Unfortunately, on Fodor's account of narrow content, this ***cannot*** be done, as we shall now see.

Is Narrow Content Inexpressible?

In his "Individualism and Supervenience," Fodor (1986, 1987) tries to respond to Burge's question begging charge by emphasizing the fact that *doppelgangers* would have the same causal powers if placed in the same contexts. However, Fodor succeeds in undermining narrow psychology far more than he does in supporting it, I shall argue, when he maintains that the "narrow" content shared by the twins is ***inexpressible***.

Before the Twin Earth challenges, those in the Fregean tradition believed that the content of a sentence or a thought was a function which would pick out the extension of its terms, and the conditions which would make it true or false; e.g., the statement "It's raining" has the content it does because it is true if and only if it is in fact raining in the circumstances in which it is uttered. Related to this idea that sense determines reference (i.e. that the same content should pick out the same extension), was the thought that sameness of extension was thus a ***necessary*** condition for sameness of content. However, the Twin Earth examples seemed to wreak havoc with this identity criterion for intentional content, since the Twins instantiate the same internal functions, yet one picks out H2O, while the other denotes XYZ, which suggests that the content of their "water" concept is not the same.

Fodor (1987, p. 46), however, submits that the Twin-Earth examples can be accommodated without violence to the old notion of content, since "extensional identity still constrains

intentional identity because ***contents*** still determine extensions relative to a context'." According to this view, two people's thoughts would be the same if they would pick out the same things had they been embedded in the same linguistic and/or environmental context; or as Fodor (1987, p. 48) puts it, "your thought is content-identical to mine only if in every context in which your thought has truth condition ***T***, mine has truth condition ***T*** and vice versa." Although the contexts and hence truth-conditions and "broad" or wide content of the Twins are *de facto* different so long as they remain on their separate worlds, their "water" thoughts have the same narrow content, because they would pick out the same range of wet stuff as instances if placed in the same context.

So far, so good; the central insight of this more contextualized conception of the relation between content and truth-conditions can be viewed as a special instance of the same "causal powers" argument which asserts that molecule for molecule *doppelgangers* are psychological twins as well because they would do the same things in the same circumstances. However, when it comes to saying just what it is that the English words and their Twin-English homynyms ***do*** mean in common, apart from the contexts which "anchor" them to determinate truth-conditions, Fodor (1987, p. 50) confesses he *cannot* say, because "the content that an English sentence expresses is *ipso facto* anchored content, hence *ipso facto* not narrow." This is why Fodor (1987, p. 53) calls his view a "no content" account of narrow content, because he holds that the narrow content mapping functions with the context left unspecified are ***inexpressible***:

> Narrow content is radically inexpressible, because it's only content ***potentially***; it's what gets to ***be*** content when – and only when – it gets to be anchored. We can't – to put it in a nutshell – ***say*** what Twin thoughts have in common. (1987, p. 50)

Although Fodor doesn't seem to think so (since he concludes, "Let...rejoicing be unconstrained!": 1986, p. 362), this is a disastrous result for narrow psychology. If Fodor is right about narrow content being inexpressible, then it is pointless to argue about whether it exists or not. If we can't actually say what the narrow content of someone's thought is, then we can't actually provide individualistic explanations for someone's behavior which describe their (narrow) intentions. That explains why Fodor never attempts to defuse the question begging charge directly by describing the Twins' supposedly equivalent actions and behavioral intentions in narrow terms: he doesn't think it's even ***possible*** to do so. Burge and the "wide' psychologists thus win by default: at least they can give wide explanations, for Fodor grants them the use the "anchored" natural languages with which to ascribe beliefs and desires, whereas would-be narrow psychologists seem to be precluded from being able to offer narrow intentional explanations. Thus, it seems that narrow psychology can't even get out of the starting gate, because even if it could provide an account of narrow content, it couldn't actually deliver or apply narrow explanations, and so it would be impotent as a practice.

Before I respond to these various wide challenges and objections to the very idea of a narrow psychology, I shall now take a moment to collect them together and summarize them.

Summary: Philosophical Challenges to Narrow Psychology

"Narrow" psychology is guided by the methodological principle known variously as methodological solipsism or the principle of individualism or autonomy, which can be roughly expressed as the idea that the explanatory states of interest to psychology are "in the head." Based upon developments in the philosophy of language by Kripke, Putnam, and others concerning causal and historical theories of reference which conclude that meaning is **not** in the head, anti-individualists such as Tyler Burge (1979, 1986) and Keith Quillen (1986) have argued that normal propositional attitude explanations (such as someone consulting a doctor ***because*** he believed he had arthritis) violate the individualistic premise, since the contents they ascribe are at least partly individuated in terms of the physical and social environments in which the subject is embedded. Submitting that the best judge of the dispute should be what works well in actual psychological theorizing,[60] they maintain that individualism is therefore mistaken, since their counterfactual thought experiments seem to show that actual attributions proceed according to wide criteria, and that "indiscernibility with respect to chemical, neural or functional histories does not entail indiscernibility with respect to propositional attitudes" (Quillen, p. 141).

Unfortunately, the anti-individualists' view has been bolstered by Fodor's own arguments which were supposedly presented in narrow psychology's defense. On Fodor's (1980) account, MS is supposed to guide the way psychologists should frame explanations, but when it comes to attributing content-laden, intentional states, it reaches a cul-de-sac, since according to his (1986) conception of narrow content, it cannot actually be expressed. Given Fodor's own views, this isn't surprising: considering that he endorses indicator semantics, or what he calls "slightly less crude" causal theories of content which identify meaning in terms of more-or-less reliable responses to external objects (see his 1987, Chapter Four), he isn't truly a defender of narrow intentional theories at all. However, in view of the fact that he wrote the influential (1980) paper ostensibly in support of MS, his concessions to the unworkability of narrow psychology in practice appear to be all the more damning.

Fortunately, however, Fodor is not the only advocate of narrow psychology. In the Sections which follow, I shall be exploring a different approach which has been sketched by Dennett (1982) and Loar (1985, 1987), in the attempt to solve the inexpressibility problem and to respond to the question begging charge by actually providing a narrow intentional explanation. Furthermore, I shall flesh out some of the more metaphysical and philosophical arguments in favor of narrow psychology which were first skeched in Section 2.1, in order to motivate proceeding. But first, in order to reinstate at least portions of the classical view, I shall explain how many of the objections of the causal account of reference can be accommodated by a descriptivist approach, and also draw attention to the internal factors which are presupposed by even these so-called New Theorists.

On How Wide Meaning Presupposes Narrow Content

In this Section, I shall attempt to defuse some of the objections to narrow content which emanate from the causal theories of reference by pointing out the extent to which the causal theorists need to acknowledge and even presuppose the resources of the narrow account in order to explain

[60] See Burge (1986, esp. pp. 9-12, 24-25), and Quillen (1986, p. 152).

phenomena such as malapropisms and our ability to use language to refer to things in the first place. As we'll see, although Kripke and other formal semanticists tend to pass off such considerations as belonging to "pragmatics," rather than to semantics proper, individual psychology is interested in such pragmatic phenomena, i.e., in the way people use words to convey their thoughts, intentions, and world-views.

Reference, Competence, and Intentions

As we saw, the causal theorists submit that names and natural kind terms are "rigid designators" which refer to the essential natures of things, and can tolerate a lot of ignorance and error on the part of the speakers who use them. However, even if that assertion ***is*** correct (and there are certainly grounds for doubting it, in the case of kind terms[61]), the first point to appreciate is that terms can only be used to refer – rigidly or otherwise – by competent language users. Parrots, after all, don't refer, when they merely parrot our words, nor do people who utter what they take to be nonsense syllables, but which actually correspond to meaningful utterances in some foreign language. It turns out, however, that the causal account can only get underway by presupposing an account of linguistic competence and referential baptisms which requires *referential* intentions on the part of speakers of the very sort detailed by the internalists' descriptivist account.

Let's start with the first link of the referential chain – the baptism or christening. According to Putnam,[62] as we saw, whoever originally coins a rigid designator has to intend to pick out <stuff of the same underlying structure as the originally ostended sample>, rather than <stuff with the same superficial features>, or else "water" would apply indiscriminately to both H2O and XYZ. As description theorists such as Searle (1983, p. 204) have pointed out, the 'same-stuff-as-this'

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[61] Do we intend to use kind terms "rigidly," rather than non-rigidly or more superficially? Putnam and Kripke assert that we do, of course, but there are grounds for doubt. One problem, as Michael Dummett (1974, p. 530) argues here, is that Putnam is in effect turning all terms into technical terms by maintaining that only the experts fully understand the correct application of the term:

"It would be possible to maintain that ordinary English speakers have only a partial grasp of the sense of 'gold', that jewellers have a somewhat more comprehensive grasp of it, but that only chemists fully grasp it; but it would surely be perverse, for it goes against the grain to say that ordinary speakers do not fully understand a term of ordinary speech. We are not, after all, in disagreement about the facts, which are that the criteria for the application of 'gold' used by ordinary speakers are sufficient for ordinary purposes, but that such speakers are willing to yield to the criteria employed by the experts, and unknown to themselves, in extraordinary cases. If we say that only the experts really understand the word 'gold', we obliterate the genuine distinction between such a word and a genuine technical term [such as 'amino acid']."

However, if ordinary folk do fully understand terms such as "gold", as Dummett suggests, then it would seem that they're not rigid designators referring to the same micro-structure across possible worlds. Perhaps the semantics of most normal kind terms is that they apply to things which have a cluster of properties (shape, color, markings, thickness, etc.) resembling stereotypical or prototypical examples, as is surely the case with "mitten" – regardless of its microstructure, anything that has a certain shape and thickness which enables it to be worn to warm hands is a mitten. It might be that we no more intend to refer to the microstructure of water, gold or tigers than we do to mittens'. In some cases, as Putnam (1975a) himself notes, we do] countenance distinct types of substances as belonging to the same kind, in virtue of their strong superficial resemblances: e.g., there are two types of jade – jadite and nephrite. If jade is more typical of the rule then the exceptions, then the "Twin Earth" arguments collapse: the *doppelgangers* would have the same propositional content, because they *would* have the same concept of water, because the indiscernible differences between XYZ and H2O would be irrelevant.

[62] E.g., see Putnam (1973, pp. 127-30), or his "Why There Isn't A Ready-Made World," reprinted in Putnam (1983, pp. 220-21).

intention itself incorporates an internalized description, so at this stage, at least, the causal account presupposes the descriptivist one. The view that the speaker's intension determines the extension of his terms is not affected by the fact that he doesn't know all the relevant facts, such as what kind of micro-structure water has, Searle (1983, p. 205) argues, as we can see from parallel cases such as when the intension of a speaker's expression, "The murderer of Brown," determines as its extension the murderer of Brown, whether or not the speaker knows who in fact that is.

The fact that the christener of a term has to have a certain description in mind is brought out further by Devitt and Sterelny (1987), who are themselves advocates of causal theories, who draw attention to what they call the "Qua" problem. One way of putting the problem is, "Just *what gets baptized*? When someone holds a new kitten and dubs it "Nana," for example, does the name refer to i) the cat; ii) a moment of the cat's existence; or iii) some particular part of the cat? Obviously, which it is makes a difference to the truth-value of statements about Nana, such as, "Nana weighs 5 lbs." As Devitt and Sterelny (1987, pp. 64-65) note, this apparent indeterminacy of reference is only resolved by the intentions of the grounder of the term:

> ...there must be something about the mental state of the grounder that makes it the case that the name is grounded in the cause of the experience *qua whole object*....It seems that the grounder must, at some level, "think of" the cause of his experience under some general categorial term like 'animal' or 'material object'. It is because he does so that the grounding is in Nana and not in a temporal and spatial part of her.

As Devitt and Sterelny (1987, pp. 74-75) go on to point out, the Qua problem is more extensive than merely intending to pick out whole objects rather than parts, when we consider the problem of what *kind* of "kind" we intend to name when we categorize animals, for example, since

> Any sample of a natural kind is likely to be a sample of many natural kinds; for example, the sample is not only an echidna, but also a montreme, a mammal, a vertebrate, and so on....The relevant nature is the one that is, as a matter of fact, responsible for the properties picked out by the descriptions associated with the term in the grounding.

Moreover, internalized descriptions are also of crucial importance in accounting for the fact that there are ***empty*** names which fail to refer to anything. The example Devitt and Sterelny (1987, p. 61) give concerns someone who insists that "Tilda, the extra-terrestial I saw last night, is real!" Such assertions are meaningful, albeit false, and the significance of names such as "Tilda" and (presumably) non-referring expressions such as "extra-terrestials" depends solely upon our intentions to refer to something, and the description of the referent we have in mind. Empty names are quite troublesome for externalist theories, because there is nothing outside to pin their meaning *to*. Sometimes, of course, something was indeed present in the ostensive circumstances, as when people designated hysterical or schizophrenic women as "witches," but reference fails, nonetheless, because *there are no witches*, since nothing has the power to cast spells. Such considerations show that representations in the head are essential to determining reference, or its absence.

Of course, externalists may concede that the initial stage of christening names and kind terms involves certain referential intentions and descriptions on the part of the namer to give them a determinate reference, yet go on to point out that very little of our everyday language use involves naming things afresh. More often, it involves ***borrowing*** the expressions others have

initiated. What about these subsequent stages of the referential chains – are internal representations critically involved here, as well? Again, the answer is "Yes." Kripke (1980, pp. 96, 163-64), for example, points out that the links in the historical chain which trace back to the originally designated object crucially depend upon our intention to keep the chain going – we must also intend to refer to whatever it is our source was referring to.[63] Linguistic competence – the ability to acquire and use referring terms – thus requires some cognitive sophistication. Similarly, even Wittgenstein (who is ranked by Burge [1979], p. 173 as an anti-individualist) argues in his ***Philosophical Investigations*** (1953, pp. 13-19) that language users require a certain amount of internal conceptual apparatus before they can become competent. We cannot learn the meaning of terms, even those taught ostensively, unless we already know what category (such as number, color, person) to fit them into: e.g., as Wittgenstein (1953, p. 13, par. 28) puts it concerning a case in which we try to teach someone the meaning of "two" by pointing to two nuts, "The person one gives the definition to doesn't know what one wants to call 'two'; he will suppose that 'two' is the name given to *this* group of nuts!" The point is, if the subject associates a name or term with a radically wrong category, he will not be competent in its use; e.g., as Searle (1983, p. 249) remarks, if someone hears about Plato's philosophy of mathematics and comes to believe that "Socrates" refers to an odd number, he doesn't truly refer to Socrates when he says "Socrates is not a prime." When the borrowing goes awry, we have what is called a reference ***shift***, as when Marco Polo mistakenly applied "Madagascar" to the island instead of the mainland.[64] In cases of reference shifting, when the speaker's referential intentions are paramount in determining what is being said (i.e. in fixing reference), the externalists' story thus goes back to the descriptivist's square one, because it is what the speaker means by his term that determines what he is thinking about.

Thus, competent speakers, and not just the original namers, must have referential intentions which associate general categories (e.g., person, place, thing) with the terms they use, so it shouldn't be supposed that language users only have meaningless syntax in their heads. Nor is the act of borrowing reference itself incompatible with the descriptivist account. Even Peter Strawson acknowledged that we sometimes borrow reference from others, and explained how our intention to borrow someone else's reference is itself a type of identifying description.[65] Kripke (1980, p. 90) illustrates how this would work: "I may then say, 'Look, by "Godel" I shall mean the man Joe thinks proved the incompleteness of arithmetic."[66] Similarly, Searle (1983),

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[63] E.g., Kripke (1980, p. 96) writes, "When the name is 'passed from link to link,' the receiver of the name must, I think, intend when he learns it to use it with the same reference as the man from whom he had heard it. If I hear the name 'Napoleon' and decide it would be a nice name for my pet aardvark, I do not satisfy this condition."

[64] See Evans in Schwartz (1977), or see Kripke (1974, pp. 514-15).

[65] E.g., see Strawson's ***Individuals*** (1959, p. 182 n.): "The identifying description...may include a reference to another's reference to that particular....So one reference may borrow its credentials as a genuinely identifying reference, from another; and that from another. But this regress is not infinite."

[66] Kripke (1980, p.92), however, rightly criticizes Strawson's view for being overly stringent, since "Strawson apparently requires that the speaker must know from whom he got his reference, so that he can say: 'By "Godel" I mean the man Jones calls "Godel".' If he does not remember how he picked up the reference, he cannot give such a description." Kripke maintains that we can refer to Godel even if we misremember or forget where we derived the name from, and this seems right in the cases of famous personages. Few of us can remember who first told us of Columbus or Washington, but we are inclined to think that even if what we think about them is mistaken (maybe Chris sailed in 149**3**), we refer to them nevertheless. It does seem mistaken to think that reference borrowing must involve a definite fix on the source; Strawson should never have adopted such a singular view. It's often a general intention to refer to

updating his 1958 account of proper names, also maintains that reference borrowing (or what he calls "parasitic" cases of reference) is in basic accord with descriptivist accounts, on the grounds that parasitic references are only successful if some further speakers have enough intentional content backing the name to identify its bearer.[67] In other words, we cannot pass the referential buck forever – at some point, someone has to know what the terms the other people are borrowing mean, if we are to do more than merely parrot one another.

Of course, while the idea that we *borrow* reference via certain intentions might well be assimilated by the descriptivist account, it is of not much help to individualism, since it seems to bear out the very moral Putnam (1983, p. 145) draws from the Twin Earth examples, namely, that there is more to meaning than the "narrow" meaning which *is* in the head – there's also "the ***reference*** of the word, as objectively fixed by the practices of the community ... extension is fixed collectively and not individually." Accordingly, let's concentrate on the cases where even the advocates of the New Theory of Reference such as Kripke have to concede that it is the speaker's intentions and descriptions which determine his reference.

Speaker Reference

In the article of the same name, Kripke (1977, p. 256) distinguishes between "Speaker Reference and Semantic Reference":

> ...let us distinguish, following [Paul] Grice, between what *the speaker's words* meant, on a given occasion, and what ***he*** meant, in saying these words, on that occasion. For example, one burglar says to another, "the cops are around the corner." What *the words* meant is clear: the police were around the corner. But *the speaker* may well have meant, "We can't wait around collecting any more loot: Let's split!"

The phenomenon of speaker's reference encompasses not only the fact that (like the burglar) we often use words to express far more than their literal face value, but also the fact that we may sometimes use names even if they ***don't*** apply historically: e.g., as Kripke (1974, p. 514) notes, some people have countered his theory by saying, "Well, look, surely sometimes when I use the name 'Aristotle' I want to be talking about the guy who wrote this book in front of me, whether the historical Aristotle really did." As Kripke (1974, pp. 514-515) goes on to explain, he doesn't think that this harms his *semantic* theory, however, because like Burge, he thinks that competent speakers will ordinarily correct their usage if they discover that its erroneous:

> That's true, but that also is a case of utterer's reference, and he will withdraw the name 'Aristotle' if he really discovers that Aristotle didn't write the work, because then he would realize that the semantic intention doesn't coincide with the utterer's intention. So I don't think such an example is an example in favor of, say, Frege and against me. It's a matter of distinction of utterer's reference and semantic reference. Now what's the difference between the semantic reference and the utterer's reference? A semantic reference is when a speaker forms a general intention, say, always to use the name 'Smith' to

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whoever "those in the know" mean. However, this more liberalized view can also be accommodated by the descriptivist account, as Searle explains in the next note.

[67] Searle (1983, p. 243) writes, "...often the only identifying description one associates with a name "N" is simply the "object called N in my community or by my interlocutors." In such a case, my use of the name is parasitic on other speakers' use of the name in the sense that my reference, using a name to which I can attach only the Intentional content "called N," is successful only if there are now or have been other people who use or have used the name "N" and attach semantic or Intentional content of a completely different sort."

> refer to a certain guy. His utterer's reference is an intention to refer to *that* guy by using the name 'Smith'. He thinks they coincide, but if he's wrong, they diverge.

Similarly, Burge's (factual) patient had intended to refer to the aching ailment in his thigh when he said he had arthritis there, even though according to strict semantic criteria he wasn't referring to anything at all, since "arthritis" doesn't apply to thighs. However, call it what you will, it *is* the speakers' intentions to refer that are of interest to the investigator who want to understand their attitudes, because it is what *they* have in mind that explains why they behave as they do. Kripke (1974, pp. 515-516) however, offers a kind of transcendental argument for why we should assign the wide or borrowed meaning to the speaker's utterances, rather than the subject's – we simply ***must*** have wide intentions to refer, lest we should be talking past each other instead of communicating!

> One reason I think the historical theory is true and why the intention to use the name as you've heard it is primary, as against your beliefs which may fit something else, is this: that we use names to talk to each other, and if you're using it with a different referent from the hearer just because of your own private beliefs, you're not going to be talking to him. Therefore we have a strong bias in favor of keeping the referent fixed if our beliefs about the object become erroneous.

The problem with this "stong bias" in the context of trying to understand someone's actual attitudes is that it completely obscures the goal of the investigation, which is to understand *their* mind-set, not what their words may *conventionally* mean. The point is, often we're **not** talking about the same things when we converse, and when there is divergence because of the subject's private beliefs, intentional psychologists (as opposed to sociolinguists) want to find out just what the individual is thinking of, not some default value – for that, we could consult dictionaries, textbooks, or historical journals, instead of bothering to interview the subject. Again, even though he relegates them to the domain of "pragmatic considerations" (rather than "semantics" proper) Kripke (1977, p. 265, n. 22) himself concedes that people use words in their own ways, that "In ordinary discourse, we say that the speaker was referring to someone under a wide variety of circumstances, including linguistic errors, verbal slips, and deliberate misuses of language," and that we must thus take the subjects' beliefs and intentions into account in order to understand malapropisms ("If Mrs. Malaprop says, 'The geography teacher said that the equilateral triangles are equiangular,' she *refers* to the geometry teacher") as well as cases of sarcasm or irony, when someone uses a name to refer despite knowing that it doesn't historically apply (e.g., "if Smith is a lunatic who thinks he is Napoleon, they may humor him... [and] say '"Napoleon" has gone to bed'").

The lesson to draw from such cases thus seems to be that the way someone uses a term determines the extension of the term as he or she uses it, even though it may diverge appreciably from the community's usage. The fact that the externalists recognize the existence of both types of meaning (the speaker's and their community's) in their examples concerning speakers' ignorance and error, yet maintain that the latter should normally override the former in determining the reference of someone's terms suggests that these philosophers of language have an altogether different project in mind than understanding people's attitudes. As Howard Wettstein (1986, p. 201) argues in his "Has Semantics Rested on a Mistake?" that is indeed the case, because while Fregean accounts set out to solve puzzles about opacity and identity

statements[68] by giving an account of the cognitive significance of terms, the New Theory of Reference (which minimizes the importance of senses and substitutes a more direct picture of the language-reality relation) is engaged in a distinct project:

> Where Frege's primary focus was on the connection between language and the mind...the new theorist is largely unconcerned with matters cognitive. His interest is in the connection between language and the world, the realm of referents. He is doing the anthropology of our institutions of natural language, and he wants to understand the institutionalized conventions in accordance with which our terms refer.

Suffice to say that the intentional psychologist ***is*** concerned with matters cognitive, i.e., with the relationship between the thoughts going on in individuals' mind/brains and the behaviors they exhibit in the world, and so it is appropriate for them to concentrate upon the language-world relation that is mediated by the subject's thoughts, theories, ideas and memories – what Frege calls the "modes of presentation" – in order to understand their attitudes, rather than the ostensibly more "direct" language-world relation which is mediated through a maze of historical chains reaching back to initial baptisms, or through the consultation of the community's experts who try to delineate the proper extension of technical and quasi-technical terms. In support of this last claim, in the next two Sections I shall explain in more detail what the explanatory goal of individual intentional psychology is and why wide individuations of content seem to run afoul of it, and then describe how narrow psychologists can actually go about giving narrow intentional explanations. I'll start with some of the more philosophical reasons for preferring the narrow approach.

Philosophical Arguments In Defense of Narrow Psychology

As we've seen, the operative assumption of narrow psychology is that "cognitive behavior is necessarily a function of the way an organism *represents* the world, but not necessarily a function of the way the world *actually* is," as Marras (1985, p. 304) puts it; consequently, it factors the following out of psychological explanations: whether our beliefs are *true*; whether they actually *refer* to external objects; and what those actual referents *are* in their essential nature, as conceived by third parties. In this Section, I will flesh out some of the more philosophical arguments which have appeared in the literature to bolster the intuitions on behalf of excluding such factors.

Let's start by quickly reviewing some of the broadly Cartesian grounds for regarding truth and reference as psychologically irrelevant. Once again, the basic idea is, since subjects are in no position to distinguish between genuine perceptions and systematic hallucinations at the time of acting, it makes no difference to their ensuing behavior which it is: they act on the situation as they construe it – ***as if*** what they see is real (in the words of Vaihinger). Nor does the ***truth*** of our beliefs directly affect our behavior, since whether or not our epistemic limitations, biases, and standards of evidence permit genuine knowledge of the external world, we act on the basis of our beliefs, nevertheless, even if they're not true.

[68] E.g., Lois Lane believes that Clark Kent is at his desk, but not that Superman is, although both names refer to the same man; and while "Clark is Superman" seems significant, "Clark is Clark" does not. I will be returning to the matter of referential opacity in Section 2.5.2.2 below.

As for the fact that the objects of subjects' attitudes (such as water) can be given more sophisticated scientific characterizations (such as "H2O" or "XYZ") than they themselves hold, these, too, should be excluded from figuring in as constructs in intentional explanations, for several reasons. First, like truth and reference themselves, they seem to be "explanatorily inert" features (in the words of Quillen [1986], p. 142) which are quite suspect as causal agents, because they are in no position to play a role in the production of behavior. Second, by ascribing conceptions to subjects that they aren't cognizant of, we will sometimes be forced to make discriminations which don't seem to correspond to any psychological or behavioral differences. And third, and perhaps most importantly, if we ascribe the experts' conceptions to subjects vicariously, rather than sticking to their own, sometimes we won't be able to make sense of behavior which did make sense from their point of view. Let's go over these points in turn.

On Remote and Proximate Causation

The main philosophical reason for rejecting wide or externalist explanations of behavior which individuate content along social and environmental lines instead of limiting themselves to the subjects' conceptions of things is a metaphysical one: wide content is unsuitable to the explanatory task, because it's not a plausible candidate for being the proximate cause of behavior.

This point has been argued by a number of commentators, including Stich (1984) and Devitt and Sterelny (1987, pp. 165-66), but here it is expressed admirably by Peter Godfrey-Smith (1986, pp. 224-25), who remarks that even when our beliefs are about real things, it's hard to see how the "baroque" external chains linking our thoughts with their referents could possibly have an impact on behavior:

> ...if the externalist constraint [that content is determined by external factors] holds, then part of what determines what object an agent's belief is about, and what states of affairs is desired, is outside the head, [but] what causes behavior is just what is *inside* the head. So far as the production of behavior is concerned, reference and truth-conditional content are causally impotent. And, further, the environmental facts involved in folk ascriptions of content are not likely to be *simple* ones. If the causal theory is on the right track, then the environmental facts which determine semantic properties are fantastically intricate and baroque. Your tokens of the word 'Caesar' are causally linked to an unimaginable number of environmental objects and events, but the semantic properties of those tokens are determined by their links to a particular man who lived in Italy thousands of years ago. If what 'thinking about Caesar' comes down to is a matter of mazes of intricate historical and social facts, then it is hard to see how a notion like 'thinking about Caesar' could possibly be of any explanatory utility.

Of course, it is one thing if the subject has some idea who Caesar was, which would account for his wanting to go to Rome to see any monuments he might have, etc., but quite another if he has *no* idea and literally doesn't know him from Adam; in the latter case, it is quite mysterious how *other* people's knowledge of Caesar or the past transmission of the name could possibly be affecting the subject's current behavior.

Similarly, Fodor (1986) offers a satirical argument against relational construals of mental states which concerns a "gen-u-ine" American 10-cent piece which is ascribed the power of being able

to change the universe from one containing H-particles (which is anything that exists when the dime is heads up) to one containing only T-particles (when it's tails). Noting that the relational property of being an H-particle or a T-particle is *causally* irrelevant to the behavior of things in the universe, Fodor submits that it would be "simply mad" to incorporate it as an explanatory construct in particle physics (p. 236), just as it would be a mistake to differentiate between virtual twins who happen to live in worlds with different sorts of phenomenologically indistinguishable wet stuff in their puddles, he argues, since "These sorts of differences in the relational properties of psychological(/brain/particle) states are *irrelevant to their causal powers*; hence irrelevant to scientific taxonomy" (p. 243). Hence, as Fodor concludes, it would seem that a causal explanation should individuate mental states *non*-relationally, i.e., according to what *is* in the head.

This point about the diffuse nature of wide content and its questionable relevance to causal explanations stands out further once we consider that if wide meaning or content "ain't in the head," as the externalists put it, then neither are the wide *beliefs* being individuated, as McCulloch points out,[69] which makes their application to behavior seem questionable at best, since they don't seem to be in a position to cause it. What **is** in a position to produce behavior, as even externalists such as Devitt and Sterelny note,[70] has been variously called "psychological content," "narrow conceptual role," or "narrow causal role," which is located squarely within our brains. As Block (1986, p. 668) explains,

> To have an internal representation with a certain narrow meaning is to have a representation with certain likely inferential antecedents and consequents. Hence, to ascribe a narrow meaning is to ascribe a syndrome of causes and effects, including, in some cases, behavioral effects (or at least impulses in motor-output neurons). E.g., the conceptual role of the word "and" in someone's cognitive economy is to link thoughts together, and the conceptual role of a term such as "dog" is constituted by the various images and internalizes sentences or thoughts a subject associates with the term (E.g., "Dogs make good companions"), and these in turn are associated with his dispositions to behave in the face of what he regards as 'doggish' stimuli.

Wide content, on the other hand, doesn't supervene on the subject's physiology because it essentially involves some external objects being referred to (such as the bearer of the name) and/or some communal authorities or practices for determining the referents. As such, it doesn't do the subject himself any good in causing his behavior (all but his referring behavior, that is), since the whole point of representations for an active organism is to mediate between the

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[69] McCulloch (1986, pp. 62-63), for example, argues that it follows from Putnam's slogan that "Meaning ain't in the head" (since "the reference of the words used are themselves, somehow, part of the meaning that the classical theorist must characterize") that "Beliefs ain't in the head," either, since, "If meanings individuate beliefs, and the specification of meanings involves extracranial items like London, then the individuation of beliefs also involves such items. ...In particular, we have the result that whereas Ralph believes that London is pretty, ...[twin]-Ralph believes that [twin]-London is pretty, and the non-identity of London and [twin]-London is enough to ensure that...[we] ascribe different beliefs to our *Doppelganger*."

[70] See Devitt and Sterelny's argument in favor of narrow psychology in their ***Mind and Language***: "Suppose that Oscar and Twin Oscar both token, "Water contains hydrogen." What Oscar says is true but, unless XYZ contains hydrogen, what Twin Oscar says is false. Yet these semantic differences make no difference to the internal psychologies ... [which] are identical, according to the fantasy. Yet those psychologies determine the behaviors of Oscar and Twin Oscar, which are also identical, of course. So the semantic differences are irrelevant to explaining behavior. ... The conceptual role of the thought, itself part of the explanation of reference, is relevant to the explanation of behavior. But the full-blooded notion of reference, and hence truth, is not. ... Truth and reference are not in the head, but behavior ***is*** caused by what is in the head." (pp. 165-66)

environment and its responses, as McGinn (1982, pp. 211, 215) points out, which is why only the internal aspect of the meaning of mental states seems suitable for explaining our actions. To say otherwise, in favor of an externalized conception of agents' operative representations, seems to be opting for some sort of action-at-a-distance account, by maintaining that the more conventional or scientific concepts that are somehow "out there" in the practices of the community are somehow involved in remotely controlling the local behavior of the subject. (Note that the description Burge [1979], p. 114 uses for this supposed mechanism, which he admits as being "more than a little vague," is "inertial force," as in: "the expressions the subject uses take on a certain inertia in determining attributions of mental content to him.")

Of course, this charge about the 'spooky' causation implicit in Hegelian or neo-Hegelian conceptions of cognition and purposive behavior isn't new, so what do the latter-day externalists have to say in their defense? Burge does address himself to this issue directly, but as we shall see, his reply isn't very convincing. First, Burge (1986, p. 16) agrees that "a person's mental events and behavior are causally affected by the person's environment only through local causal effects on the person's body," but then he adds,

> Without the slightest conceptual discomfort we may individuate mental events so as to allow distinct events (types or tokens) with distinguishable chemistries, or even physiologies, for the subject's body. Information from and about the environment is transmitted only through proximal stimulation, but the information is individuated partly by reference to the nature of normal distal stimuli. Causation is local. Individuation may presuppose facts about the specific nature of a subject's environment.

The problem with this response is that it sounds an awful lot like Burge is talking about *de re* attitudes when he says we "may presuppose facts about the specific nature of a subject's environment" and individuate content along environmental lines in good conscience, even though it may not be reflected in any differences in the subject's physiology. The objects of *de re* attitudes are whatever things in the "real world" the attitudes are related to or about – tables, chairs, people, etc.; *de re* beliefs, for example, "are those beliefs which involve believing *of* some object that it has some property," as B. L. Davidson (1985, p. 391, my emphasis) puts it. Clearly, the full content of such attitudes fails to supervene on the agents' physiology, since the tables, chairs, etc. perceived or desired are *out there*, rather than in our heads. However, *de re* attitudes are not the proper focus of intentional explanations, because they are insensitive to important intentional phenomena such as ***opacity***: the fact that people may sincerely and even vehemently assent to one characterization of their attitudes, but not another, despite the fact that the only terms which differ in the two attributions actually refer to the same subject (without their knowing it, of course).[71] As such, *de re* readings are apt to find behavior incomprehensible or blatantly irrational which makes perfect sense from the subject's point of view: e.g., someone may agree to, "You believe that Adolf Hitler was an evil man?" while sincerely dissenting from "So you believe that Adolf Shickelgruber was an evil man?"; similarly, someone who would never dream of tormenting Superman (whom he fears) may act on his desire to publicly humiliate Clark Kent (whom he views as cowardly). This makes one suspect that Burge's thought experiments are simply collapsing the concepts that subjects *are* thinking with the ones they in

[71] This phenomenon of changing the truth-value of a sentence by substituting one of its expressions by a co-referring one is one of the logical peculiarities of the intensional sentences which report on intentional states, and has been called "referential opacity" by Quine, in his "Reference and Modality," which is reprinted in his *From a Logical Point of View* (Harvard University Press, 1980). I shall be turning to another of the peculiarities of intentional contexts, which concerns the existence of the putative objects of belief, in Section 2.4.2 below.

some sense *should be* – if they only knew what they were looking at or truly talking about. But even if Burge isn't talking about *de re* content in this passage when he advocates wide individuations, he seems to be granting content-eliminativists like Stich (1983) everything they want when he says "Causation is local" – which seems tantamount to saying that the content he's attributing isn't really involved in the production of behavior – since they can perfectly well object that it makes more sense to individuate local causes locally, rather than according to external categories which have no additional influence. But Burge's response isn't through; in his (1986, p. 20), he adds:

> Unlike action-at-a-distance theories, [non-individualist] psychology does not appeal to action at a distance. It is true that the aspects of the environment that do not differentially affect the physical movements of the protagonists in the thought experiment do differentially affect the explanations and descriptions. This is not, however, because some special causal relation is postulated, but rather because environmental differences affect what kind of laws obtain, and the way causes and effects are individuated.

Here Burge sounds like he's trying to have it both ways: he admits that the wide differences being talked about don't affect our external movements (or our inner dialogue, either, as Putnam notes), yet he holds that they should figure into laws nevertheless. But what kind of laws could these be, since ***explanatory*** laws aren't just descriptive generalizations relativized to some environment or society – they involve genuine causal processes? Things get even worse, however, when we consider the nature of the mechanism the externalists are appealing to and what it portends for causation: the disposition to defer. Burge (1979, pp. 101-102), for example, grants that a more liberal interpretation of "means something different" implies that the deviant subjects in his examples mean something different by their words, when, e.g., they submit that they have 'arthritis' in their thigh, but he submits,

> The argument from deviant speaker-meaning downplays an intuitive feature....The subject's willingness to submit his statement and belief to the arbitration of an authority suggests a willingness to have his words taken in the normal way – regardless of his mistaken associations with the word. Typically, the subject will regard recourse to a dictionary, and to the rest of us, as at once a check on his usage and his belief. When the verdict goes against him, he will not usually plead that we have simply misunderstood his views. This sort of behavior suggests that...we can say that in a sense our man meant by 'arthritis' *arthritis*...despite... his incomplete understanding.

Thus, when the chips are down and individualists argue that neither Oscar nor his twin have a concept of arthritis, Burge's recourse is to appeal to the subject's willingness to have his usage corrected. This starts to sound a little like backwards causation, however, since Burge seems willing to explain a subject's past behavior by appealing to the intentional content they *would* have in the future, if they were to have the opportunity to consult the relevant expert and have their misconceptions corrected or their ignorance relieved (and backwards causation, of course, is an extremely suspect notion in the natural sciences).

Of course, in reply, Burge can reiterate that "causation is local" and hasten to add that he doesn't mean to imply that the parts of a term's meaning that subjects were ignorant could actually be implicated in *causing* their behavior – it just affects how we should *conceive* of their thought or behavior. However, it now appears that the externalist view is best understood as a ***normative*** approach to human behavior, rather than a genuinely explanatory one. Burge gives support for this reading both when he defends wide attributions in his (1979, p. 114) on the basis that, "Global coherence and responsibility [to the language community] seem sometimes to override

localized incompetence," and again in his "Intellectual Norms and the Foundations of Mind," when, after distinguishing between the cognitive value of a term for an individual and its conventional linguistic meaning, Burge (1986b, p. 117) writes, "Conventional meaning provides norms for ideal competence by reference to which a person's usage and beliefs may be corrected." This difference between the normative view (about what we ***ought*** to be thinking if we were held accountable to our community's linguistic conventions) and the explanatory approach (which restricts explanations of the subject's behavior to what he or she ***is*** thinking) is brought out by Burge (1979, p. 114) himself when he remarks that non-linguistic animals don't seem to be appropriate candidates "for misunderstanding the contents of their beliefs," as he puts it, so his argument in favor of wide explanations doesn't go through for them. This is somewhat ironic, since although the other animals may not be smart enough to be able to speak a public language or to borrow reference from others, at least their behavior is caused by their own brains and they act for reasons of their own. However, as the Churchlands (among others) have argued, any psychological theory that has radically different accounts of the behavior of humans and animals is suspect on evolutionary grounds.[72] Of course, many will agree that there's something quite different about human and animal cognition, thanks to our use of language, but that's because language can help us to focus our thoughts and it's useful for communicating ideas to one another; but in Burge's view, the important thing about a social language is that it lets others *do our thinking for us*, which makes it something of a mystery how our behavior is being caused.

These, then, are some of the reasons why we should be suspicious of the externalist's ontology and of whether they can deliver reputable causal explanations at all when they go about ascribing wide attitudes. But since we certainly don't want to rest everything on *apriorism* in this dispute about an empirical science, as Burge (1986, p. 22) says in connection with these types of complaints, let's see why it would be a bad idea for individual psychology to individuate widely, because they result in generalizations which are sometimes too fine-grained, and sometimes too coarse, to be useful.

Some Externalist Individuations Are Too Fine

To a practicing clinician, the Twin-Earth arguments may appear to be quite irrelevant to their purposes, considering their other-worldly character. However, externalism can't be refuted by simply pointing out that psychology deals with real Earthlings in actual societies, not in counter-factual societies or imaginary types of water or extra-terrestials, since nonfictional examples exist, too, as Stich, for example, has observed concerning chicory and endive;[73] and similarly, Putnam (1983) has tried to bring his example down to Earth, although only by way of a fictional society which uses and speaks of a different metal as if it were aluminum, and he draws a similar moral about meaning not being in the head.[74] Consequently, the externalists' examples cannot in

[72] E.g., see P.M. Churchland (1979), or P.S. Churchland (1986) on naturalistic arguments against overly linguistic conceptions of human psychology; I'll be returning to them in Chapter Six below.

[73] Stich (1983, pp. 63-64) points out that the reference of "chicory" and "endive" are reversed in America vis-a-vis Britain, and many subjects lack the expertise to discriminate which is which, and depending on where someone is, his audience will take his utterance, "Chicory is bitter," to be referring to different things and to have a different truth-value.

[74] In his "Computational Psychology & Interpretation Theory" (which was read at a U.W.O. conference in 1982 and published in Putnam 1983, among other places) Putnam, no doubt sensitive to criticisms of the irrelevancy of "sci-fi" examples, reconstructs the problem without appealing to doppelgangers, possible worlds, and time travel.

good conscience be simply dismissed as beside the point, so I do grant that the thrust of their claim ***is*** relevant to clinical settings, but in these next two subsections I shall be arguing that exclusively wide methods of construing individuals' communications would actually be ***counter-productive*** if they were to be pressed into service, because to the extent that they diverge from narrow indivduations, they tend to be either ***too fine*** or too ***coarse*** to be of much use to individual psychology – either they force distinctions between (narrowly) equivalent subjects who actually have the same psychology, or they fail to make sense of or discriminate between subjects who use the same public language but actually have quite different underlying world-views. We'll start with the former point.

Although I grant the wisdom of letting conventional interpretations determine the reference and truth-value of someone's speech in ordinary, casual, "bus-stop" conversations where one's interlocutor may simply be giving a slightly garbled report of what he's heard on the news, rather than stating his own views, this same principle of interpretation can sometimes force distinctions which aren't reflected in psychological differences, and so it seems too fine-grained and apt to sacrifice generalizations or explanatory unifications. To see this, let's start with the notorious 'water' case, but with a morbid twist.

Suppose that there ***is*** a Twin Earth, and that we even come to explain a marooned Twin Earthling's behavior. Suppose he's crash-landed in Nevada, and he's stumbling around, parched with thirst, when he encounters a greedy prospector, who (being American) tells him that there is indeed some water in his canteen, but he can only have some if he ***buys*** it. Naturally, the astronaut hadn't thought to bring either cash ***or*** American Express (because he didn't imagine they'd take either one where he was going), but his need is genuine and he insists, and in the ensuing struggle he is forced to kill the would-be profiteer. According to Putnam, it would be *false* to say that he committed the act because he needed and wanted some *water* (although he will testify something that sounds an awful lot like that in his own defense), because Twin Earthlings have never had contact with water (i.e., H2O) – it's *schwater* he wanted and was attempting to refer to (i.e., XYZ). This misses the point, however, which is that this desperate man, like many others, would kill for XYZ, H20, or anything else which would prevent him from dying of thirst; forcing discriminations between him and his Earthling counterpart (who also had the misfortune to crash-land and find himself having to bargain for a drink to save his life, though *ex hypothesi* it would be a different sort) which obscure their essential similarity.

Similarly, take the case of gold, which is also apt to be involved in violent episodes, given the value we place in it. Scorning the non-essentialist construal, Putnam (1979, p. 285), for example, writes,

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Imagine now a place called "Ruritania" where the silver (or molybdenum, it doesn't matter which) pots and pans of Elmer's northern province seem just like the pots of his twin Oscar, who lives in the south, where they use aluminum; and imagine both provinces say, "Pots are made of *grug*." Before they learn chemistry, Oscar and Elmer have had the same sort of pots-and-pans experiences from their point of view, so, "... it would seem that we should say that the content of the mental representation of 'grug' is exactly the same for Oscar and for Elmer at this stage in their lives. I do not mean to suggest that the *word* "grug" has the same meaning in Oscar's idiolect as it does in Elmer's ...when Oscar tries to determine what *is* grug he will ultimately have to rely on 'experts' ...since the extension of "grug" is in fact different in the two communities, since ...difference in extension constitutes difference of meaning, and since extension is fixed collectively and not individually, it ends up that the *meaning* of the word "grug" in the idiolects of Oscar and Elmer is not the same even though there is nothing "psychological," nothing "in their heads," which constitutes the difference in meaning. *Meanings aren't in the head*."

> I think actually 99% of the extension of the word 'gold' is fixed by the substance itself. If you leave out the modern period when we know the atomic composition of gold and so on, and take 99% of the time people have talked about gold, what people had were only paradigms; even the ability to pick out those paradigms reliably was most of the time possessed only by experts, not by the lay speaker. But 'gold' was used as a name not only for the paradigms, but for whatever *was of the same nature* as the paradigms... if 'gold' simply meant *whatever passed the operational test*, then Archimedes could just have gone to the king and said "I have read Bridgman, and something is gold if it passes the operational tests; it passes the operational tests, so your crown is gold" and then he would have had his head chopped off and the king would have gone to a better scientist!

Putnam has a point about the limitations of operational criteria in science, of course, but his example can be turned on *its* head when it comes to understanding our everyday behavior. It's all well and good to say that people only intend to refer to what's ***really*** gold, but we shouldn't discount the importance of their own identifying criteria, because that's what comes into play when 'gold'-directed behavior is involved. So although externalists may try to convince Archimedes that the yellow-metal jewelry he had made for his wife isn't really gold in the name of scientific precision, individual psychology mustn't follow suit, for it isn't just concerned with the mental states of idealized cognizers and experts, but of *anyone*. We ***want*** to know whether someone thinks shiny yellow metals are valuable gold, even if the extension of their "gold" is too broad for the expert's tastes, for this person might just kill any expert who tampers with his shiny yellow metal, whatever it is.

Similarly, a variant of Burge's example about diseases can bring home the fact that we shouldn't automatically assign different contents to the beliefs of identical twins who happen to live in different cultural or environmental contexts. Let's consider a case with a great deal more significance for everyone involved than the trivial "chicory/endive," "brisket," or "Who is Jefferson?" examples, which concerns a horribly debilitating lethal condition which is increasingly becoming implicated in the ultimate act: AIDS. Consider what "AIDS" could mean to a pair of identical twins who happened to contract the disorder a few years apart.[75] "AIDS," of course, is an acronym for Acquired Immune Deficiency ***Syndrome***. Unlike the more specialized "disease" – which is sometimes restricted to conditions with a single recognizable etiology – "syndrome" is a broader category, defined at the symptomatic level;[76] for the time being, we categorize AIDS as a syndrome because it doesn't seem to be caused by a single virus. However, suppose, for the sake of argument, that the search for "the AIDS virus" pans out in the year 1992, and it turns out to be a disease, although it also turns out to be incurable, nevertheless; however, almost everyone continues to *call* it "AIDS" for reasons of habit and phonetics. Thus, according to this distinction (which is every bit as significant as the difference between water and "t-water") people have actually been dying from AIDD's (i.e., Acquired Immune Deficiency Disease) and not just AIDS. Now consider how this could impact on the twins' psychology. First, in 1990, Oscar discovers that he's tested positive for AIDS, and he decides to commit suicide rather than face a painful, drawn-out death, and he says so in a note when he writes, "I've got AIDS, and I can't stand the thought of dying like that." His twin brother Elmer, who has led a

[75] I owe this example to Michael Dietrich, who first pointed out to me the distinction between diseases and syndromes in connection with AIDS.

[76] E.g., the DSM-III (1980, p. 368) defines "syndrome" so: "A grouping of symptoms that occur together and that constitute a recognizable condition. The term "syndrome" is less specific than "disorder" or "disease." The term "disease" generally implies a specific etiology or pathophysiological process. In DSM-III (1980) most of the disorders are, in fact, syndromes."

similar life-style, is terribly grieved, but he doesn't dare have himself tested, and he refuses to read or hear anything further about the dreaded subject after his brother's death, but things go well in the ensuing few years, as no abnormal symptoms develop. Eventually, however, the problem manifests itself, whereupon he, too, writes that he'd sooner die by his own hand than face such a demise, and he carries out that resolution. But ***why*** did the twins perform that ultimate act? On Burge's account, while it would surely be an exaggeration to say it was just an "orthographic accident" that the twins both used the term "AIDS" to mean different things, technically they killed themselves for different reasons (albeit ones that bear "some striking, superficial similarities," as Burge [1982], p. 110 puts it), because in 1993, the coroner would say that Elmer committed suicide because he discovered he had acquired the immune deficiency disease, whereas when Oscar died in 1990, the medical community would deny that he had a disease at all, and since *ex hypothesi* both twins were disposed to defer to the experts' usage should any present themselves to correct their usage (as in Burge's examples), they must be reckoned as having different reasons. However, I submit on behalf on narrow psychology that this Burgean judgment is simply **wrong** – the twins kill themselves for exactly the same reason, even though the experts in their community at these different times would have different conceptions about why they were doing it. When Elmer dies, he has all the same old popular ideas as Oscar had about the nature of their condition and what they would have been in for without this desperate expedient; accordingly, it surely seems that they killed themselves for the very same reason, which they duly recorded in their suicide notes: they ascribed the property of having AIDS to themselves, as that term is currently understood.

Putnam, however has already attempted to accommodate such cases by emphasizing the importance of the referential component of natural kind terms, rather than the shifting ideas of the experts. Putnam (1979, pp. 284-85), for example, addresses the analogous case of multiple sclerosis, and says,

> ...what is the continuity in the meaning of a word like 'multiple sclerosis' if it is neither that the scientists necessarily use the same tests at different times, nor that they give the same theoretical account? I think the continuity is 99% sameness of reference. The "meaning" is the same as long as by the light of our later theories we are still using 'multiple sclerosis' as the name for the same disease, making that decision from within our current theory and making the normal adjustments due to charity.

But this appeal to the continuity of the thing being referred to won't help here, since we can adjust for that, too. Suppose it turns out that "AIDS" is a predicate somewhat like Goodman's 'grue', in that in involves two strains: the type encountered *before* 1992 (which had a variety of causes), and the type encountered *after* 1992 (which we will know to be a disease caused by a single virus which withstood all the drugs that wiped out the previous kinds), and so suppose it turns out that Oscar and Elmer weren't really suffering from the *same* condition after all; on the wide account they should be counted as killing themselves for different reasons, but that seems to fly in the face of what we know to be their identical "internal monologues" (as Putnam puts it) on the subject.

The point of these examples is, the wide method of individuating content sometimes marks differences in content when there is no psychological difference between the subjects. Consequently, it multiplies the number of explanations it needs to understand people's reasons for behaving, and in so doing, it sacrifices generalizations across cognitively equivalent subjects

who happen to be embedded in different linguistic communities or environments. In addition, wide attributions would prevent us from adequately making sense of subjects who were transplanted from their original environment in ways they weren't aware of. This can be brought out by an example Keith Quillen (1986) puts forward to illustrate what an anti-individualistic intentional psychology would look like. After criticizing narrow psychology for the inadequacies of description theories and prototype perceptual theories (following the "either/or" dictum of philosophers, he does *not*, significantly, consider a combination of the two), Quillen proceeds to demonstrate how a wide psychology can accommodate Twin Earth scenarios using an example concerned with dogs: here on Earth, Jones occasionally pets *dogs*, but that's a behavior his *doppelganger* never actually exhibits on Twin Earth, where the dog-like creatures are actually genetically different somehow (although these differences don't manifest themselves in ways Jones could discriminate); wide individuations of beliefs, Quillen (1986, pp. 152-53) comments, are

> ... *tailor-made* for explanations of the different behaviors, so construed. Jones pets dogs because he believes that dogs are friendly and deserving of affection, while his twin pets tdogs because he believes that tdogs are friendly and deserving of affection.

However, although it may seem more accurate from the referential point of view to say that the doppelgangers engage in the petting behavior for different reasons (one because he likes dogs, the other, 'tdogs'), externalists fail to see that relational or wide explanations are patently inadequate as soon as the Twin Earth objection is put to them. Suppose our Jones is whisked off in his sleep to Twin Earth, and upon awakening, as is his wont, he retrieves the morning paper, and beckons and reaches over to pet a passing neighborhood pooch, which is *ex hypothesi* a tdog rather than a dog. Now, *why* did he pet the tdog? Surely not because he thinks that tdogs are friendly, since according to the externalists' story, he was in no position to have beliefs about or concepts of tdogs until this very moment, and he wasn't taken aback by the sight and he certainly doesn't take himself to have discovered some new manner of beast. But if he didn't think that tdogs are friendly, his behavior would then appear to be quite baffling, arbitrary, or even reckless, on the wide account, since he approached and even accosted what after all could be a ferocious creature, one which he had no prior information about or experience with. A narrow psychologist, on the other hand, would regard Jones's current behavior as of a piece with his customary practice, and wouldn't be at a loss to explain it – Jones patted the tdog for the same (narrow) reason he pets dogs: intuitively, because he had the long-standing desire to pet what he regards as friendly dogs (whatever their genetic composition happens to be), and because he took himself to be in the presence of a friendly dog.

Wide attributions, then, are sometimes too fine, in that they force discriminations between subjects who are equivalent for individual psychology's intents and purposes, since they have the same internal representations and dispositions to behave. But a more pressing and realistic loss (than failing to recognize that Twin Earthlings are psychologically equivalent) which also results from scrupulously wide content ascriptions is that they would fail to make the proper discriminations between subjects who use language differently – that is, wide individuations of content are sometimes too coarse, as I shall now go on to argue.

Extensionalist Ascriptions are too Coarse

Sometimes wide attributions are too coarse, in that wide criteria would force psychologists to count subjects as the same (due to similarities in their public language use or their referents) who are actually acting for differing reasons of their own. In other words, the "wide" hermeneutic approaches sometimes cast their interpretive nets ***too*** wide, because by concentrating on the social or environmental meaning of someone's communications, they can sometimes fail to make important discriminations in their psychological content, to use Brian Loar's (1987) terminology.

We are speaking here, of course, about the difference between the language of society, and the language of – thought. Not that this language of thought has to be implemented in quite the formalized way that Fodor (1975) envisions, of course, but even non-solipsistic philosophers (such as Vendler,[77] Dufrenne,[78] and countless others, including Burge himself[79] join Fodor in thinking that thought and language are intimately connected, and intentional psychologists (e.g., Vygotsky 1962) have held the same, for similar reasons: i) as mentalists, they are all committed to some medium of mentation or other, and a language is certainly suited to the task; ii) complex, abstract thought, at least, only seems to arise in young humans after they have acquired a language, which enables them to extract and differentiate themselves from the immediate external world they were previously so thoroughly engrossed by, and to treat it at a certain level of abstraction; and iii) thoughts and plans continue to be accompanied by "inner speech" in our own case, as well. But putting aside non-verbal animals for now (as Burge does), the problem that immediately arises once we acknowledge the role of language as it functions in an individual's thought *in addition to* its social role is that these roles can diverge, i.e., the elements of a language may have a different function in the thought of an individual than they have in his or her society as a whole, and consequently, there is a tension between narrow and wide construals of someone's language use which threatens to engulf intentional psychology's explanatory goal.

The problem arises, as Dufrenne (1967, p. 206) explains here (without actually putting it in terms of "narrow" and "wide", since his discussion predates Putnam and Burge's) depending upon

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[77] See Zeno Vendler's *Res Cogitans* (Ithaca, N.Y.: Cornell University Press, 1972) for his view that language is essential to thought.

[78] E.g., in his "Language and Metaphysics" (1967, pp. 207-208, 212), Mikel Dufrenne, a philosopher at the Sorbonne, writes, "... Thought [may be defined] very summarily, as the manipulation of representations....To become conscious of the world is also to become conscious of oneself as a distinct pole of reference. To think requires this distance with respect to the world, a distance that is expressed by the "re" in representation....It is language that introduces the requisite distance between the signifying and the signified. It is by the mediation of language that the interval is created where thought can come into play...[a] mediation...that separates and unites at the same time. If language digs a trench between the world and me, it also throws a bridge across it...language is the very mediation between the "I" and the world which...I am able to name."

[79] Although Burge (as well as myself) certainly grants that non-linguistic animals have some sort of beliefs, and he says "Animal ratiocination is ontogenetically prior to any use or understanding of linguistic symbols" (1986b, p. 713, n. 14), his argument in favor of wide attributions depends upon the "intellectual responsibility" (*ibid*.) associated with language use, as we saw, and he also says (in 1986b, p. 118), "One approach, distinctive of this century, is to explicate thought in terms of linguistic meaning and thinking in terms of using symbols with such meaning. A more traditional view is to explicate linguistic meaning in terms of thought. A third view, which I regard as correct, is that the two notions are interwoven in complex ways which render it impossible to fully analyze one in terms of the other."

which perspective one emphasizes – "the usage that man makes of language...man as speaking," versus "the ownership that language has of meaning...language itself as speaking":

> ...on the one hand, to consider the human being as a being who speaks, tempts one to see in a language a tool, of which man is the master and which he can make according to his taste, precisely as the logicians do. Consequently, one is tempted to affirm the primacy of thought over language and the arbitrary character of linguistic signs. But, on the other hand, to consider language as language that speaks tempts one to see in language a reality which both precedes and outruns thought, which instructs thought without thought's having any initiative whatsoever, and which proceeds not from man so much as from the world.

As we've seen, the externalists emphasize the latter perspective, when they say things like "the extension of a term sometimes fixes its meaning and not vice versa" (Putnam 1978, p. 114), and "much mentalistic attribution does not presuppose that the subject has fully mastered the content of his thought" (Burge 1979, p. 105). In what follows, however, I shall argue why we are more justified in adopting the former view in order to avoid the coarseness of conventional, social, or environmental interpretations and understand and explain the behavior of individuals, because a "wide" construal of the contents of someone's utterances is often wide of the mark.

We've already seen something of this point above, in the light of phenomena such as misspeaking or slips of the tongue, malapropisms, irony, sarcasm, and slang.[80] But since the externalists (e.g., Burge 1979, p. 90) grant that a translation is called for in these sorts of cases, let's move on to consider cases involving both of the major categories of speech that externalists emphasize: names and kind terms. We'll start with names, using the example made famous by Kripke (1979) himself: the puzzling (for an externalist) case of Pierre, with his apparently contradictory beliefs about London. As the story goes, Pierre assents to "Londre est jolie" to his dying day, because of what he'd heard about Buckingham Palace and such back in France, but he vehemently denies "London is pretty" once he's lived with other immigrants in an East-end slum and learned a little English. According to the causal theory's criterion for fixing the reference of names back to its historical bearer, and the usual principles of translation, Pierre believes both that London is pretty and that London is not pretty, and thus he seems guilty of harboring a contradiction. That's bad news for either Pierre or these principles of attribution, however, because a contradiction is enough to ruin any rational deductive system (since under a principle of closure the subject is committed to believing any well-formed statement whatsoever), and if Pierre is patently irrational, then according to some intentional theorists (e.g., Dennett) he doesn't even qualify as an intentional agent. However, those implications seem to fly in the face of the other facts we may know about Pierre: he seems rational in all other respects, and he even holds a job as an eminent logician who would brook no formal contradiction if he were to know about it (in Lewis's [1981] elaboration). Instead, the moral of the story seems to be that we have to be more sensitive in the way we individuate content. The fact is, even if "London" and "Londre" are co-referential or even synonymous according to some accounts because the public at large uses both names to designate the same thing in real life, they have come to mean quite different things (or at least to have different cognitive roles, in McGinn's [1982], p. 247 terminology) in the mind of the individual concerned; or as Loar (1987) puts it, they don't have the same psychological content (since Pierre may still think he might like to live in the pretty city called "Londres"

[80] See Section 2.3.2 above on malapropisms and linguistic errors; P.F. Strawson once provided such an example of intended meaning which involved a cleaning lady's unwitting use of a double negation, in response to Russell's emphasis upon the importance of definite descriptions.

where Oscar Wilde once lived, e.g., but he's disposed to say that London itself is ugly). Given these facts about how Pierre acquired and uses these names, there's nothing irrational about him, but an externalist principle of attribution which overlooks these differences is too coarse to make sense of his behavior.

But since a Burgean might reply that the names involved can be traced back to different linguistic communities and so admit their psychological difference, now let's consider kind terms as examples, including variants of Burge's own case of arthritis (where he definitely doesn't think that any special translation is called for), in order to illustrate how externalist attributions can be both too fine and too coarse at the same time. We've already seen how Burge's individuation of the content of the patients' belief is too ***fine*** while considering how it discriminates between the Twins when there is no difference in their behavioral dispositions and inner life, but the fact that it's also too ***coarse*** can be shown by restricting our attention to Oscar the Earthling alone. Attributing the *arthritis* concept to Oscar, as Burge emphasizes (rather than, say, the 'twarthritis' concept the Twin Earth society has), despite the significant differences in his use of the term (such as its presumed application to the long bones, as well) may seem harmless enough, if the patient is simply generalizing "arthritis" to apply to more rheumatoid ailments (such as bursitis) than it really does, since the consequences don't seem to be too serious either way. But suppose the case *is* more serious and the subject does something drastic on the basis of his or her misconception; e.g., suppose that after his thigh has ached for a while and he says to himself that he has arthritis in his thigh, the formerly vital Oscar doesn't just meekly enquire of his doctor whether he truly has it, but rather, he jumps off a bridge to avoid becoming crippled and helpless, because he takes "arthritis" to refer to a very serious degenerative bone condition such as what we would call "osteoporosis." If Burge were to interpret Oscar's departing note as indicating that he believed that he had *arthritis*, he would be in no position to make sense of the suicide – if it happened that arthritis was a far less serious condition than Oscar imagined himself to have, that is. (Unfortunately for thousands of sufferers and my example however, that isn't always true, since arthritis can indeed be crippling, but the point about making sense of otherwise inexplicable behavior in the light of a subject's expanded or altered concept, has been made by others concerning cases with less drastic behavioral consequences.[81]) Or take an expression whose individual and social applications have generated some heated consequences over the years: consider what two individuals in our society might mean when they call someone a "Communist." If they *are* from the same society and they're reasonably competent, the externalists must say they mean the same thing, but consider what "Communist" means for a character like Archie Bunker (any kind of "liberal, Pinko, homosexual, etc." who didn't vote for Reagan and happened to disagree with him on almost anything, or was the least bit different from him), versus what it means for someone who only uses it to designate card-carrying members, or certain specified (and virtually non-existent) socio-political arrangements. The latter may admire communist principles and consider it a term of approbation, while for Archie, a "Commie" is someone who undermines the moral fiber of America and should be locked up or

[81] E.g., discussing the same arthritis example, even someone who advocates "An Externalist Account of Psychological Content," Akeel Bilgrami (1987, p. 195), submits that Burge's "...way of thinking of content and its determinants cripples content for its explanatory function and so forces a second notion of content...it yields individuations of content too coarse-grained to always capture the inferences or failures of inference in agents to whom they are attributed. For instance, if Bert here knows there is special balm for arthritis and thinks that he should apply it to the condition in his thigh, an account in which concepts [are] socially constituted...will not be in a position to capture the practical reasoning by which he moved from one thought to the other."

shot; any investigator who ploughed over these differences would be unable to account for the fact that if the host of a party was introduced to them as a Communist, one would become deferential, and the other, abusive. To make sense of these behaviors, it would be best to ascribe the beliefs to them they truly have: the cordial guest thinks the host is a Communist who cares about the interests of the poor, while Archie thinks he's something terribly corrupt.

Of course, Burge has encountered this response before, which he describes as wanting to reinterpret the object-level beliefs of subjects with diverging concepts. In reply, he neither denies the existence of independent narrow thought (indeed, he even acknowledges in his [1986b] that an individual thinker can turn things around entirely by correcting *conventional usage*[82]) nor that "frequently when a person incompletely understands an attitude content he has some other attitude content that more or less captures his understanding," to use his own (1979, p. 95) words. Nevertheless, he apparently thinks that it would be too difficult to even *bother* making a narrow attribution tailored to the individual by coining a new term, if need be, in lieu of the standard wide concepts:

> There are reasons why ordinary practice does not follow the method of object-level reinterpretation. In many cases, particularly those involving partial understanding, finding a reinterpretation...would be entirely nontrivial....Consider the arthritic patient....We make up a term 'tharthritis' that covers arthritis and whatever it is he has in his thigh. The appropriate restrictions on the application of this term and of the patient's supposed notions are unclear. Is just any problem in the thigh that the patient wants to call 'arthritis' to count as tharthritis? Are other ailments covered? What would decide? The problem is that there are no recognized standards governing the application of the new term. In such cases, the method is patently *ad hoc*...[and] it proliferates terminology without evident theoretical reward....It is simpler and equally informative to construe him as thinking that arthritis may occur outside of joints. (1979, p. 94)

However, although we may not bother to do so in "ordinary practice" when people are chatting with us, I fail to see why it would be *ad hoc* or without reward to take individual subjects' variations into account and to reinterpret what they're saying more in accordance with their actual and possibly quite idiosyncratic conceptions, if we want to understand and explain their individual behavior. That is the goal of the psychological explanation, after all; in fact, Burge even admits as much in his (1986b, p. 717), when he distinguishes between the cognitive value of a term for an individual and its conventional linguistic meaning, and notes,

> They are responsible to different paradigms, and their explanatory purposes are distinct. Cognitive value is fitted to explicating possible differences in attitudes – cognitive perspective. Such differences are invoked to explain action and epistemic inquiry....Conventional meaning, by contrast, is fitted to describing reflective agreement on the means of conveying, in short order, accepted usage.

So when subjects ***don't*** conform to accepted usage (as in Burge's thought experiments) and our goal is to explain their actions rather than to describe the ordinary meaning of their utterances, then, whether or not this is what we "typically" or "ordinarily" do (which is what Burge keeps emphasizing), it seems far more logical to individuate the contents of their beliefs along

[82] Invoking the theme of the Socratic dialogues, Burge (1986b, pp. 714 ff.) concedes that individual thinkers can correct social meaning by challenging the social norms behind the concepts, such as "Sofas are pieces of furniture...[of a certain construction]... meant for sitting," by questioning the "of a certain construction" part, e.g. The point can be made more acute if we adapt the example Burge discusses on pp. 10-11: consider a counterfactual society that thought sofas were art objects; some radical thinker could awaken them to the idea that they are things not so much to be admired as they are to be sat upon.

cognitive or psychological lines rather than conventionally, which means that when their conceptions deviate significantly from the norm (in a sense relevant to their actions), an individualized reinterpretation is in order. Sometimes this will require us to coin a new word, but more often, it will require a translation into pre-existing terms.

In sum, externalist attributions are sometimes too coarse, and as a result, they obscure differences in subjects' underlying belief content; moreover, on this scheme of individuation, subjects may appear to be far more irrational than they really are, and certain behaviors that are quite understandable by narrow content standards would seem inexplicable. Not only are wide construals of subjects' mental states sometimes too coarse, but sometimes they're too fine; i.e., sometimes they license too many distinctions and generalizations, and sometimes not enough. Just for the record, however, it should be emphasized that these two failings don't balance out – they make the wide approach doubly wrong.

Thus, we have seen the reasons to suppose that narrow content exists – the externalists need to presuppose it in order to complete their own account – and we have seen some reasons why intentional psychologists should prefer to use it in their explanations of behavior, if they can. However, there still remains the problem of whether they ***can*** express narrow content, so let's turn to that, now.

Narrow Content and Intentions to Behave

As we've seen, the mere fact that the external motions of two subjects are identical is not enough to show that they have the same psychology or even the same behavior. In other words, "behaving isn't to be identified with moving one's body," as Fodor (1987, p. 36) puts the Burgean objection. In order to judge whether the behavior of doppelgangers ***is*** the same, we must first identify how "behavior" is to be construed for the purposes of intentional explanations. Accordingly, I shall begin this Section by arguing that for the purposes of intentional psychology, behavior is not to be construed just in terms of movements performed, or in terms of the effects achieved, but rather according to the way the subject (consciously or unconsciously) conceives of his or her action. Next, I will argue why we should think that the behavioral intentions of *doppelgangers* are the same, and finally I will explain how a narrow psychologist could say what those narrowly conceived intentions to behave are.

Behavior and Intentions

As we've seen, the thrust of the Twin Earth examples is that mere equivalence of bodily movements is not sufficient to establish sameness of behavior. Two people can make the same *noises*, for example, without *saying* the same thing, if they are actually speaking different languages (as the externalists contend is the case for the Twins). Moreover, their identical movements can produce the same effects, but that, too, is insufficient to make their behaviors identical. E.g., we sharply distinguish between a case in which an actor shoots and kills someone onstage on the basis of the false (but justified) belief that the gun was loaded with blanks, and a case involving identical movements, but where the actor knows that live ammunition has been substituted. Although both actions are homicides, they count as different actions, since one is

accidental and excusable, while the other is deliberate and presumably inexcusable. Analogously, the action of a capricious subject who wantonly shoots a man he knows only as "old Mr. Schmidt" differs from the action of someone who sees through the alias and shoots Schmidt because he knows him to be the notorious Klaus Barbie; only the latter is an act of vengeance. This takes us to the essence of the *intentional* aspect of intentional psychology: we must be sensitive to the way the subject conceives of his action. Like other intentional contexts, descriptions of intentional behavior are ***opaque***, which means that their truth value isn't always preserved when their terms are substituted by co-referring ones. In this case, the thug might confess to shooting Schmidt, but he would sincerely deny that he's ever taken a shot at Klaus Barbie, even though that's what he managed to do.

Identical real world consequences are not even *necessary* conditions for identical behavior, much less sufficient. The same intended action can have different effects, due to luck, or a difference in context. Think of the times you changed lanes while driving without signalling or checking properly, and got by, in contrast to the time when you did the same thing and nearly paid for it with your life. Or consider a case Harnad (1987) raises in connection with categorization: a Russian woman is accustomed to picking mushrooms of a certain appearance to make a soufflé for dinner; she then emigrates to America, and engages in the same intended behavior – she picks mushrooms of identical appearance, in accordance with her unchanged concept, for the same purpose. Unfortunately, her action now has different effects, for she now unwittingly picks a different kind of mushroom, one which is poisonous.[83] However, the fact that the American mushrooms end in her demise rather than her satiation does not alter the fact that she was trying to pick her favorite mushrooms, and thus her behavior was the same as it had been formerly, so far as an intentional psychologist is concerned (although not so far as a coroner is concerned, of course). The contextual factors which are responsible for the differing effects of her behavior are psychologically irrelevant, just as in Stich's (1983) example, the fact that his newly created clone cannot (legally) sell Stich's car since he doesn't actually *own* it doesn't affect the fact that he is *trying* to sell it because he sincerely believes he owns it, etc.

The issue to be decided regarding psychological causal powers, then, is whether two subjects have the same ***intended*** behavior, however much their movements resemble one another, *and* whether or not the actions have the same effects. As we'll see, the advocate of narrow psychology holds that the *doppelgangers* are like the transplanted mushroom gatherer: they engage in the same intended behavior, although their differing contexts make it the case that there are different effects. To establish that their intended behavior is the same, we have to show that they conceive of their actions the same way, by showing that they have the same notion of what they are doing – the same narrow content.

Notional Content

[83] One of Nature's tricks: to stave off predators, many benign edible organisms mimic toxic ones. Then they are either avoided, or they get revenge when their eater moves on to the poisonous look-alikes.

Is there any way to say just what the *doppelgangers* are thinking, and what they intend to do, when they say "I want a glass of water," and go to their respective kitchen sinks? As we'll see, there is, by developing Dennett's (1982) sketch of ***notional content***.

To begin with, let's consider what the content of their thought is ***not***. By hypothesis, the Oscar Twins are chemically naive, so from their point they don't have the desire for H2O *or* XYZ, any more than a child who was hiding from a thunder and lightning storm would agree that she feared sound waves and electrical discharges, since she had no idea what they were. What, then, do they want? To answer this question, we need to consider the idea of notional content, which Dennett (1982, pp. 19, 36-38) introduces here:

> [What] is the ***organismic contribution*** to the fixation of propositional attitudes...what we get when we subtract facts about the context or embedding from the determining whole?...The answer would characterize psychological states 'in the narrow sense'....Let us call it ***notional attitude psychology***. We want it to work out that I and my *Doppelganger* – and any other narrow psychological twins – have exactly the same notional attitudes....Let us try to characterize the ***notional world*** of a psychological subject so that, for instance, although my *Doppelganger* and I live in different real worlds – Twin-Earth and Earth – we have the *same* notional world. You and I live in the same real world, but have different notional worlds, though there is considerable overlap between them.
>
> ...A notional world can be supposed to be full of notional objects, and the scene of notional events – all the objects and events the subject ***believes in***...the notional worlds of gullible or confused or ontologically profligate subjects will contain notional objects having no counterparts in the real world.

As Dennett (1982, p. 38) points out, citing John Irving's bestselling ***The World According to Garp***, the idea of a person's subjective world is a familiar one, and it is reflected in everyday sayings such as, "She lives in a world of her own." But if Garp's world doesn't seem important enough for psychological scrutiny, there are the fragile glass menageries of those who do not cope with reality well, or the fractured worlds of the delusional Vietnam vets or paranoid schizophrenics who go on a rampage. In order to make sense of their behavior, we need to know: ***what's on their mind***?

A notional world, as Dennett indicates, is a composite of the properties and objects that someone believes in, whether or not they correspond to anything real. While some of us may have realistic notional worlds, in that many of the things we believe in do exist, notional objects do not have to be 'anchored' to real properties or persons, so there is plenty of room in the account for both the idiosyncratic delusions of clinical subjects and the more wide-spread beliefs in unreal properties and objects such as divinities or numbers. Since notional attitude psychology takes the individual's conception of things as primary, not the world-view of society, it recognizes that people in the same society can have radically different world views, and that people in even radically different societies could have the same beliefs.

Notional worlds are the internal models we have constructed to represent the world; they are the way we conceive things to be. Our mental lives are like movies – by thinking we each produce a fictional world with ourselves cast as the central protagonist, with our sense impressions and beliefs serving as the script defining the nature of the other characters and notional objects inhabiting the world. "Script" is meant to invoke more than a metaphor here: scripts are familiar models cognitive science has been using to implement notional worlds, as are frames, plans,

schemas, and other such default hierarchy models.[84] When we act, we extend the script by having the central protagonist interact with the set pieces. We might actually be doing something in the 'real' world entirely different from the way we conceive of our movements, however. An extreme case, as Dennett (1982, p. 48) mentions, is the near-sighted cartoon character Mr. Magoo (who would take himself to be helping a lady cross a busy street, while actually dragging a lion through an elephant stampede, e.g.): he wasn't crazy, just misinformed.[85]

As Dennett (1982, p. 44) and Brian Loar (1985, p. 15; and 1987a, p. 93) have pointed out, notional worlds can be explicated in terms of possible worlds: their contents determine the way the actual world *would* be, had the subject gotten things right. Consider, for example, a case raised by Peter Carruthers (1987, p. 24) concerning a butterfly collector who thinks he sees a valuable specimen on the wall and rushes for his net: "The content of the subject's thought is the very same as it would have been had there been a real butterfly on the wall causing their experience, and had they thought that that butterfly was worth having." This conception of narrow content thus differs substantially from Fodor's, because it doesn't start with wide content and whittle it down to a pale abstraction that doesn't really ***have*** content or conditions of satisfaction. Instead, it regards narrow content as *bona fide* content in its own right, whose conditions of satisfaction are ironically often broader than the content of the corresponding expressions as they are used by society. The reason for this is that the *wide* content of a term such as "water" often ***narrows*** the space of possibilities by correcting or precising a naive

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[84] See, e.g., Schank and Abelson or Minsky (in Johnson-Laird 1977) and Rumelhart (1980, 1986) for less global approaches to schema theory, or J.R. Anderson and G.H. Bower *Human Associative Memory* (Washington, D.C.: Winston, 1973).

[85] At this point, I should note that there are some differences between Dennett's approach to attributing notional content and my own (which follows in the text). Since I am primarily interested in defending narrow psychology, rather than in critiquing Dennett, I shall just raise them here and set them aside. Unlike me, Dennett is not a realist about intentional content. In his view, when we "adopt the intentional stance," as he puts it, we're not trying to uncover what notional world someone <u>really</u> believes in – we're trying to characterize the world their capacities and dispositions would most suit them to. According to his adaptationalist perspective, as he explains in his (1982, pp. 41-42), when we attribute contents to some organism,

> "Our task is like the problem posed when we are shown some novel or antique gadget, and asked: what is it for? ... *we try to imagine a setting* in which...it would *excellently* perform some imaginable useful function....Faced with our novel organism, we can easily enough determine what it is for -- it is for surviving and flourishing and reproducing its kind -- and we should have little trouble identifying its sense organs and modes of action and biological needs...we can figure out... for instance, that it will eat apples...[and] is disposed to make certain noises under certain conditions....Now what kind of an environment would these talents and proclivities fit it for? The more we learn about the internal structure, behavioual dispositions and systematic needs of the organism, the more particular becomes our hypothetical ideal environment...the environment...for which the organism as currently constituted is best fitted."

However, the method that we should assign notional content according to the criterion that people believe in the possible world they'd get along best in is flawed in several respects. First of all, we cannot read off someone's operative desires and motivations from evolution and biology: some people seek oblivion, not reproductive flourishing. Secondly, it is unlikely that we are "best fitted" for the notional world we believe in. Dennett's example, Mr. Magoo, responds to menacing objects as if they were familiar mundane objects, yet manages to survive, but take the obverse: Calvin (of the comic strip, "Calvin and Hobbes"), the child who sees mundane objects as menaces. While Calvin doesn't get along too well in *this* world (due to his parents' and teachers' annoyance with his continual daydreaming, etc.), he wouldn't survive for long if he were to be actually transported to his notional world populated by monsters, either – he'd probably be destroyed within moments, since he's not really the "space hero" he thinks he is. Delusional subjects probably would not get along well in *any* world, because they distort their inputs – they'd likely see the world of their dreams as something different again if they were to be actually situated there. Finally, and most importantly, Dennett's story misses the point of intentional explanation or "making sense" of behavior – it's not to do an idealized rational reconstruction of what the rationale for behaving might be, but to uncover what is actually motivating us. I pursue these themes a little further in Dow (1988).

subject's over-extended usage by restricting the extension of the term: whereas the chemically naive Oscar's belief states pick out the set of all possible worlds with watery stuff that fills the lakes and rivers and is safe to drink if it is purified, according to Putnam *et al*., ***our*** collective word "water" cuts back these worlds to just the ones containing H2O.

In Loar's (1985) terms, language is thus associated with both the ***psychological*** content of the individual insofar as he uses it to express his own notional attitudes, and the ***social*** content, or the public, conventional meaning, which is determined by the environmental context and linguistic community as a whole, including the various experts who ascertain that "water" refers exclusively to H2O. In ordinary conversations, we let the social content predominate and determine the reference (if any) of someone's speech, as when someone says "I hear fresh water is plentiful in this country," or "Jesus died for our sins." However, when we are interested in the subject's psychology, especially when their conduct and world view does not seem to fit (what we take to be) the facts well, then it is the psychological content of their utterances that we should be concerned with. E.g., if someone does things on "Jesus'" behalf, such as bomb abortion clinics, then we need to investigate their fanatical "Jesus" conception in more detail; clouded by misconceptions as it is, we may well discover that the notional character they call "Jesus" is such a caricature of the genuine article that if we were able to project their thought contents onto a movie screen, we would certainly say, "*That's* not Jesus," despite the fact that she heard the name in church and may ostensibly be intending to refer to the same historical individual as the rest of us. Similarly, both the Twins in Burge's thought experiment extend their "arthritis" term vastly beyond the range of afflictions our term applies to, since they think it applies to inflammations of the long bones, as well, so their concept is not to be identified with ours. Compare their case to a child who calls all dogs "Labs," since her neighbour has one: does she have the concept of a Lab(rador)? Not if she thinks that setters, shepherds, chihuahuas, etc., are all Labs – the range of her concept is far too great. Similarly, the psychological content of the Twins' "arthritis" concept is as different from our concept as the child's "Lab" concept is from ours, because potentially they would apply the term to aching thighs, ribs, shoulder blades, etc., whereas we restrict it to swollen joints. If we don't take that into account, we would be as baffled by their complaint that they had "arthritis" in their thigh as we would be by someone who complained that the water we served them was wet.

In short, it is the *subject's* world view that we are trying to uncover when making sense of his or her behavior, not their community's *Weltanshauung* or conventional wisdom. Social content is thus *extra*-psychological, since it is a function of the activity of society's practices, experts and so forth, and does not supervene on the physiology of individuals, but the counsel of narrow psychology is that we should only ascribe psychological content – the notions that actually play a role in an individual's cognitive economy and behavior – to describe the mental states of an individual and explain his or her behavior. The externalists, however, may object that it *is* appropriate to attribute the social content of an expression a subject uses to characterize the content of his psychological states, so long as the subject has the disposition to defer to more expert usage. The proper reply to this objection, however, is that our actual and potential *practices* belie our referential intentions. Even if we *do* intend to restrict the extension of our terms to only the things the experts would agree truly had the essential properties, and even though we (usually) intend the proper names we use to apply to some specific individual (rather than to a huge equivalence class of possible clones and *doppelgangers*), those abstract intentions

aren't relevant to our behavior, for it is our referential *practices* – our dispositions to classify and identify the things we confront (or think we do) in the world – which impel us to action. The things we ourselves would pick out as the bearers of the names or the instances of the kinds are determined in accordance with our own conceptions, which is why "fool's gold" fools us, after all. Analogously, if we were to be transported unawares to Twin Earth, we would blissfully continue to apply our concepts without ever realizing we might be *mis*applying them, since we would surely think that it was water which came out of their taps, and (to adapt Dennett's [1982], p. 52 example) we would think our *doppelganger's* spouse was our own, and the key to understanding this is that our concepts are unable to discriminate between the differences that are either discriminable only by the "experts" who key into the "hidden microstuctures" of things (on Putnam's 1975 account), or indiscriminable altogether (if our hapless subject who has been transported to Twin Earth has no way of ever telling that nobody is who he thinks they are).

The goal of intentional explanations of individuals' behavior, then, is to uncover the psychological or notional content that went into their intentions to behave. But how can this narrow content be expressed? As we'll now see, *bracketed* content ascriptions can be given, where the brackets serve to indicate that *only* the psychological content of the terms was instrumental in producing the behavior.

De Se Attitudes and Bracketed Content Ascriptions

To see how to go about ascribing bracketed narrow content, we should begin by considering the philosophical distinction between various types of attitudes which differ with respect to their *objects*. In the discussion so far, the narrow/wide debate has been centered around ***de dicto*** attitudes, which take *propositions* as their objects – those the subjects would sincerely assent to as characterizing their views. As we saw, the reason for this is that it seems inappropriate for intentional psychologists to concentrate exclusively upon ***de re*** attitudes, since otherwise rational people may think of a single object (such as Superman) according to different and even inconsistent descriptions (e.g., as both the strongest man on Earth, and as Clark Kent the weakling). However, while *de re* attitudes are obviously related to things outside the organism (which is why they're sometimes explicitly called "relational" attitudes), Burge and other externalists have argued that the content of *de dicto* attitudes does not supervene on the individual subject's physiology, either, if *doppelgangers* may nevertheless believe *different* propositions (one that he has arthritis, e.g., the other that he has 'twarthritis').

Consequently, the defenders of narrow psychology have been obliged to focus upon a different sort of attitude. Even aside from the Twin Earth cases, which primarily concerned kind terms, that much was becoming clear. As John Perry (1977, 1979), Stich (1978) and many others have argued, attitudes involving context-relative ***indexicals*** (such as "I," "here," "now") demonstrate that many *de dicto* attributions are incompatible with the requirements of narrow psychology. E.g., two subjects with very similar attitudes which they would both express as "I am about to be attacked by a bear" nevertheless believe *different* propositions, with different truth-conditions one believes ***he*** is being chased, e.g., the other that ***she*** is. But if the two people have identical conceptions of attacking bears and identical dispositions to behave as a result (e.g., to roll up in a ball and be as still as possible: see Perry [1977], p. 494) – if their 'bearish' ideas have the same ***conceptual role***, as narrow content theorists such as Block (1986) describe it – it seems

appropriate to regard their attitudes as being psychologically equivalent, despite the fact that they are referring to different subjects. Analogously for the matter of precisely ***when*** the subject's attitudes occur: that just don't seem to be relevant to explaining their behavior from their point of view. E.g., as Dennett (1982, p. 13) states the issue,

> If there is some indexical functor in my thought or belief, such as 'now' or 'today', the proposition I am 'related to' – the proposition that fills the slot in the correct propositional attitude predicate applied to me – can depend crucially (but imperceptibly to me) on such events as the moving of a clock hand at the Greenwich Observatory. But it is frankly incredible to suppose that my psycho-logical state (my behavior-predicting state) might depend not just on my internal constitution at the time but at the least also on such causally remote features as the disposition of the parts of some official time-keeper.

The moral to draw here is NOT as Stich (1978, pp. 580-81) would have it – that beliefs involving what the subject thinks about himself and what he is doing at some time and place are not relevant (or available) to individualistic psychology. Rather, it's that the objective time and place people's reasons occurred are not relevant to capturing certain useful generalizations about them. (Such as the one that would range over all the people who committed suicide right after leaving the notes bearing the message, "I'm worthless – I'm going to end it all now;" the crucial point from intentional psychology's point of view is that the subjects all thought themselves worthless, and that the time to kill themselves had come – not whatever that time may happen to be).

To help narrow psychology get around these problems, philosophers such as David Lewis have developed the idea of *de se* attitudes to capture the commonalities between psycho-logically equivalent subjects. *De se* beliefs, as B.L. Davidson (1985, p. 389), for example, notes, "are those beliefs a person holds about who and where themselves are...[e.g.], my belief that I will live for at least twenty more years." More generally, *de se* attitudes take *properties* or attributes as their objects, rather than propositions or external objects, the properties the subject would ascribe to himself, such as the property of living in a certain kind of world. Using the example of someone who believes that cyanoacrylate glue dissolves in acetone, Lewis (1983, p. 137) explains how to go about reconstruing propositional attitudes as *de se* attitudes – the subject…

> locates himself in a region of logical space. There are worlds where cyanoacrylate dissolves in acetone and worlds where it doesn't. He has a belief about himself: namely, that he inhabits one of the worlds where it does. Thereby he ascribes to himself the property of inhabiting one of the worlds included in the set which is the proposition that cyanoacrylate dissolves in acetone.
>
> So it is in general. To believe a proposition is to self-ascribe the corresponding property....A proposition divides the populace. Some are privileged to inhabit worlds where cyanoacrylate dissolves in acetone, others are not....Someone who believes a proposition, and thereby locates himself in logical space, also places himself within the divided population. He has a partial opinion as to who he is: he is one of ***this*** class, not one of ***that*** class.

Similarly, someone with the delusion that he is Hume would self-ascribe the property of being Hume (Lewis, 1983 pp. 142-143), and wishing for something is to be understood as wishing to have the property of inhabiting a world in which ___ (cyanoacrylate dissolves in acetone, e.g.: Lewis [1983], p. 145).

The advantage of this possible worlds account from narrow psychology's point of view is twofold. First, in keeping with the intentional tradition, it doesn't presuppose the existence of the putative objects of our attitudes, since, like the "intentional objects" of Brentano which Dennett

(1982, p. 39) mentions in connection with notional content,[86] the properties someone self-ascribes need not actually exist.[87] (E.g., as Lewis [1983], p. 137 points out concerning his own example, we are not privileged to actually live in a world in which cyanoacrylate dissolves in acetone, but we may think it or wish it, nevertheless.) Second, by concentrating upon the properties the agents *self-ascribe* and abstracting away from the contextual differences which don't make psychological differences, the *de se* account accommodates the fact that different subjects in different contexts can share the same attitudes, since they take themselves to be in the same situation.

As Dennett (1982, p. 39) and also Dreyfus (1982, 14 ff.) point out, together, these two features of narrow content ascription – suspending the question of the existence of the objects of thought, and factoring out third parties' conceptions – amount to a version of Husserl's "epoché" or "bracketing," also known as the "phenomenological reduction," or "phenomenology." Of course, there are far more ambitious strains to Husserl's phenomenology than intentional psychologists need to be concerned with (*viz*., "to attain absolutely valid knowledge of things" by reflecting on their essences: e.g., see Kockelmans [1967], p. 26), but the important moral phenomenological psychologists have extracted from Husserl is simply that an intentional psychologist should try to understand subjects by embracing *their* world view insofar as possible, since it is the world as they experience it that gives sense to their actions.[88] As Husserl points out, this requires that we

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[86] As Dennett suggests, Franz Brentano, the Austrian philosopher and psychologist who brought Aristotle's notion of intentionality in the sense of an active intellect to modern psychology's attention, can be reckoned as this century's premiere individualist as well. In his *Psychology from an Empirical Standpoint*, Brentano submits that "the mark of the mental" is ***intentionality***: "Every psychological phenomenon is characterized by that which the scholastics of the Middle Ages have called intentional...inherent existence of an object, and what we, although not entirely in unequivocal terms, would call the relationship to a content, the tendency toward an object [by which we do not mean a reality], or the immanent 'objectivity.' Each as an object contains something in itself, although not each in the same way. In the idea something is conceived, in the judgment something is recognized or discovered ...and so on....[The objects of external experience need not be such as they appear]...they do not exist demonstrably independent of us." (Translated by Stephen Strasser [1967, p. 334], whose insertions in brackets are included.) This means, as Strasser immediately goes on to add, that the objects of intentional acts stand "In contrast to that which really *is*, they are phenomena *only*; they do not exist *nachweisbar* ('demonstrably') but *nur phanomenal und intentional* ('only phenomenally and intentionally')." In other words, as McCall (1983, p. 37) explains, when Brentano talks about "*intentional Inexistenz*" and "immanent objectivity," he means "that the mental act always has an object but *remains within* (from the literal meaning of "immanent") the subject.

[87] The fact that agents may be centering themselves in worlds with unreal properties is thus in accordance with the well-known criterion within the philosophies of language and psychology to identify intentional states and the intensional sentences which report on them: the failure of existential implication on the part of even the singular terms involved, such that it is not legitimate to infer from "S believes that ***a*** is F," that ***a*** exists. E.g., see Chisholm's article on "Intentionality" in the *Encyclopedia of Philosophy*, vol. 4, pp. 201-204 concerning the failure of existential generalization in intentional contexts, which complements the referential opacity criterion (the fact that co-referring terms can't always be exchanged while preserving the truth-value: e.g., Ralph might believe Clark Kent is a coward without believing that Superman is).

[88] E.g., as Moss (1989, pp. 193-194) explains, the phenomenological approach in psychiatry (which we'll be hearing more about in subsequent Chapters), puts "the ***meaning of the patient's experience***" at the forefront, and has been profoundly influenced by at least parts of Husserl's approach to the traditional problems in psychology and philosophy:

"Phenomenology in philosophy was the creation of the German Edmund Husserl, who called for a "return to the things themselves" through a clearing away of assumptions and preconceptions. This methodological "fresh start" enables the phenomenologist to suspend his or her usual experience and interpretations of the world, in order to understand phenomena "as they present themselves." This philosophical new beginning immediately impressed European psychiatrists and psychologists, such as Binswanger, Karl Jaspers, and H.C. Rumke, who were seeking new theoretical foundations to understand the human being in his or her own nature, apart from the assumptions of natural science.

shouldn't presuppose that the subject's intentional states refer to anything external, and it involves bracketing out factors such as the alleged objective causal ties that natural scientists might claim our representations enjoy.[89] However, as Dennett (1982, p. 39) points out, when we press this view into clinical practice, we take some liberties with Husserl's own views, since it involves "hetero-phenomenology" to understand others, rather than simply phenomenology on oneself.

Our *objective*, then, is to convey the properties the subject of our investigation actually self-ascribes, watching for dialects, malapropisms, and idiosyncratic usages in their speech, and bracketing out such questions as whether the properties and personages they believe in actually obtain or exist. To see how this works, we should return to Putnam's Oscar Twins. Since the Twins are both ignorant of chemistry (*ex hypothesi*), it would be inappropriate to say they self-ascribe the property of living in a world in which there is H2O, *or* one bearing XYZ, since these are notions from chemistry. Instead, they have a less determinate property in mind, which they both conceive of in such terms as "the stuff that fills the lakes, that is good to drink or bathe in, etc.," so it seems appropriate to say that they self-ascribe the property of living in a world in which there is [water]. "Water," after all, isn't ***defined*** as H2O, as the causal theorists themselves grant (although it may well be what we have actually been referring to all along with the use of that term), and it seems to capture what they have in mind. The point of the brackets around the critical properties in question is to ensure that we don't overascribe any further conceptions to the subject than the ones they themselves immediately have in mind. Similarly, it would be inappropriate to say that ***either*** of Burge's patients self-ascribes the property of having [arthritis], since the condition they have in mind is much greater in scope and possibly severity; instead, although we need somewhat more detail about their mutual concept than Burge provides, it seems more appropriate to say they self-ascribe the property of living in a world in which they have [an ache in the thigh indicative of some serious bone disease].

The concepts of phenomenology illuminate the experience of psychiatric patients and the process of psychotherapy in several ways: (a) human behavior and experience reveal a nature different from that of natural phenomena and require a distinct "human-science" approach if they are to be understood, (b) psychic phenomena, behavior, and experience can be understood through their "intentional" structure, that is, they are meaningfully directed toward a situation or object, and (c) in order to understand and to reach a patient, the psychotherapist must enter into a mutual experiencing of the patient's unique world of experience, with its own time, space, and interpersonal forms."

[89] As Schmitt (1967, pp. 59-60; I have omitted his references) explains, Husserl's expression for "bracketing" out the external world was drawn from mathematics,

"...where we place an expression in brackets and put a + or - sign in front of it....In performing the reduction, the phenomenologist establishes himself as "disinterested spectator" and changes his practical aims....Previously experienced reality now becomes "mere phenomenon"...the observer...recognizes the object's claim to reality, but reserves decision on the validity of that claim. In the "natural," preanalytic and prephenomenological attitude...the "naive" attitude... we generally believe that objects perceived are real....This belief is "put out of action," suspended, we make no use of it. We are left with a world-as-phenomenon, a world which claims to be....] In this passage from his ***Ideas*** (his emphasis, reproduced in Kockelmans 1967, p. 78), Husserl himself explains that the theories and attitudes of outside scientists are not relevant to the content of the subject's own thought, except insofar as he is cognizant of them:

'I use the "phenomenological" [epoche or reduction], which completely bars me from using any judgment that concerns spatio-temporal existence (Dasein). Thus, all sciences which relate to this natural world, ...though they fill me with wondering admiration... I disconnect them all, I make absolutely no use of their standards, I do not appropriate a single one of the propositions that enter into their systems, even though their evidential value is perfect, I take none of them, no one of them serves me for a foundation -- so long, that is, as it is understood, in the way these sciences themselves understand it, as a truth concerning the realities of this world. I may accept it only after I have placed it in the bracket. That means: only in the modified consciousness of the judgment as it appears in disconnexion, and not as it figures within the science as its proposition...which claims to be valid'....'

By factoring out the differences in their environments and linguistic communities which aren't operative in their current behavior, this approach secures the desired result of ensuring that the *doppelgangers* have the same psychological states. Secondly, it does not presuppose that the properties in question *actually exist* independently of the subject's belief in them: in the [water] case, the stuff answering to the description *does* exist, but it needn't for us to believe in it, as the cases of empty names bears out – subjects can believe in mythical beings (such as gods and unicorns and leprechauns) and in idealizations and abstractions (such as numbers or freedom or justice) without actually referring to anything, but that doesn't stop them from believing in such inexistent entities or properties. Granted, it would be very difficult in practice to get a handle on what the subjects are believing if there was nothing around answering to their descriptions which they could point to in order to indicate what they meant, but this is a point about the process of discovery, rather than constitutive of the actual content of the intentional explanation. It is important to appreciate that methodological solipsism does not give the unwise counsel that psychological investigators must ***study*** subjects in total isolation, or that they cannot appeal to the subjects' behavior in the real world as ***evidence*** for what they are thinking; instead, it recommends that the ultimate explanatory posits to account for their behavior must be located within their organic boundaries. Here, to explain behavior such as why someone jumped into a pool (which may have actually contained sulfuric acid), the representations being appealed to (e.g., the subject's belief that the pool contained [water], and that [water] is good to swim in) *are* in the subject's head, and so they *do* supervene on his or her physiology, in accordance with MS's recommendation.

However, by concentrating on the Twin Earth examples of the philosophers of language so far, I, too, have been writing more or less in abstraction from the actual problem domain confronting individual psychologists, so let's turn to it and to the professionals, now.

Chapter 3

The explanations of "narrow" psychology, recall, are constrained by the principle of individualism or methodological solipsism, which restricts explanations to factors *within* the subject or actor. Having established (I hope) that it's at least *possible* for a narrow intentional paradigm to do business in Chapter Two, in this Chapter I shall explain why such a discipline *should* exist, and I'll be reviewing important branches of psychology to show that the narrow approach already *does* exist professionally, for good reasons.

Of course, "psychology is not a monolith," as Burge (1986, p. 10) himself has noted, and the methodology of some of its sub-disciplines may more properly be individualistic or narrow, and others, wide. E.g., such areas as psychophysics and the study of low-level vision, which are concerned with what wave-lengths of light we can process, and so on, should and do refer to environmental stimuli in their explanations. However, I shall be continuing to concentrate upon the level of beliefs, desires and other propositional (or *quasi*-propositional[90]) attitudes, rather than at the level of sensory stimuli, in order to explain intentional behavior. Thus, to adapt an example forwarded by the Churchlands (1983), rather than characterizing the objects of some more primitive folks' beliefs in terms of the sound waves and ionic discharges implicit in the thunder storm they are encountering, I will be focusing on their notional attitudes, which we would render as "The Storm Gods are angry with us" in order to explain why they perform a ritual sacrifice. Here again, however, I shall reduce the scope of the inquiry. I'll be leaving the ambitious theoretical battle about the status of individualism in social psychology and the social sciences generally to others, in order to wage a practically important campaign against the externalists which concentrates exclusively upon the branches of psychology that study and deal with the behavior of *individuals*. I shall review important segments of the areas of psychology I'll be lumping together for now as "individual psychology," and argue that a methodology restricted to assigning "wide" content across the board would make for *bad* psychology, not only in child psychology and abnormal psychology, as one might *expect*, but also in clinical psychology, which deals with more 'normal' subjects, as well. To establish that individual psychology is and should be individualistic, I will draw on the relevant literature to show how and why child- and clinical psychologists *do* go about making narrow attributions rather than wide, and then I will respond to some externalist objections by elaborating upon the importance of the distinction between the ***frame*** of an intentional explanation and its ***content***.

On How Thought and Language Diverge in Individual Psychology

If the externalists were to have their way, psychology would be much easier to do, if it were to adopt the ready-made reliable interpretive procedure they say is ours for the taking. To know what someone is thinking, simply "take him at his word," as Burge (1979, p. 116) puts it: just write down everything they say, and look up the words they use in the dictionaries or ask the leading authorities what they refer to! Of course, as we've already seen, Putnam and Burge not

[90] I say "quasi"-propositional attitudes here, in case we don't really encode beliefs in sentence-like structures, or if narrow beliefs don't take full-blown propositions as their objects because they just have realizability conditions or conditions of satisfaction instead of truth-conditions; see, e.g., Loar (1987), or Chisholm (1979).

only recognize but even emphasize that not everyone has a full command of the vocabulary they use (due to ignorance or error), but they apparently recommend that in most cases we should simply disregard these differences when we ascribe content to people's attitudes, since, according to their hypothesis about the "division of linguistic labour," subjects of a certain degree of conceptual sophistication[91] can simply "borrow" the information to fix the reference of their terms from the authorities, without actually having to possess it themselves, which means that psychological 'investigators' can individuate content according to external criteria in good conscience, *even though the subject only partially understands or even misunderstands* some of them, in Burge's words.[92] And according to a second externalist line of argument which also extols the importance of reference and truth, psychology's job is to study the fit between higher organisms and their external environment, and so once again psychological explanations should therefore individuate content widely, this time in accordance with the dictates of the environment.[93]

On behalf of narrow psychology, however, in these first two Sections I shall be emphasizing why things aren't nearly always so easy, since subjects can vary quite significantly in what they mean by their terms, and so a conventional or otherwise external reading of the language they use is not always the best indication of their thoughts. Of course, I'm prepared to grant that we can *say* more than we mean, as can indiscrete parrots, who recite the combination to their masters' safes; however, I shall be strenuously resisting the idea that we should ascribe content to a subject's attitudes which he or she lacks by the externalists' own admission. The trouble with wide content ascriptions is that individual psychology is primarily interested in knowing what subjects are thinking, not in what their words conventionally mean, and "If language is but the instrument for the expression of thought" (as Nolan Lewis puts it in the preface to Kasanin [1944, p. vi]) "it then comes to be just what the users make it," so we have to be prepared to put the conventional reading by the boards and try to understand the subject's communications by his or her own lights. The externalist strategies may be well and good so long as people are registering and uttering truths and speaking sensibly, but they break down as soon as they start saying things that strike us as obviously or absurdly false, such as, "This sacrificial cucumber is an ox!" (see Stich 1983) or, "I am Dionysius Christ!" (as Nietzsche reportedly claimed about himself). When that

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[91] As we saw in Chapter Two, the externalist account has to buy into a certain amount of the narrow program in order to even get going, since it requires people to have "rigid" intentions to use names and kind terms ***as*** such, and this presupposes a certain degree of conceptual and linguistic competence within the individual – not as much as the description theorists would have it, they maintain, since successful reference can tolerate a lot of ignorance and error, but some. E.g., Putnam (1978, p. 98) writes, "as long as each speaker who has the word 'gold' in his vocabulary possesses a standard minimum amount of information about gold, he or she will be able to participate in collective discussions about gold."

[92] In this passage which provides the context for the "localized incompetence" remark examined earlier, Burge (1979, p. 114) for example, submits that the "key feature" of his thought-experiment examples is that they reveal,

> "...the fact that we attribute beliefs and thoughts to people even when they incompletely understand contents of those very beliefs and thoughts.... wherever the subject has attained a certain competence in large relevant parts of his language and has (implicitly) assumed a certain general commitment or responsibility to the communal conventions governing the language's symbols, the expressions the subject uses take on a certain inertia in determining attributions of mental content to him. In particular, the expressions the subject uses sometimes provide the content of his mental states or events even though he only partially understands, or even misunderstands, some of them. Global coherence and responsibility seem sometimes to override localized incompetence." [my underlining]

[93] E.g., see Burge's (1986, pp. 12, 24 ff.) discussion of Marr in this context, or those in the "information-flow" school, such as Fred Dretske's *Knowledge and the Flow of Information* (Cambridge, Mass.: Bradford Books, 1981), or his more recent works.

happens, we often need to know in more detail just what they *are* thinking and how on Earth they *could* be thinking such things, given the sorts of actions maladaptive fantasies can inspire, and the lengths subjects are sometimes willing to go to maintain them.

As Adler (1930), Beck (1976), and countless others have found, the fact is, misconceptions can be crucially important in producing maladaptive behavior, and most if not all of our psychological problems involve a *mis*-fit between people and their environment, a faulty representation of themselves and the world, or a breakdown or jamming of the information flow, and abnormal and clinical psychology are in the business of studying these problems and attempting to rectify them. But in order for them to be able to *do* their job, it is crucial that clinical investigators understand what subjects are thinking from the subject's own point of view, if they are to explain the maladaptive behavior and attempt to ameliorate it. To bring that point home, in this Section, I'll start by discussing the tensions between the public and private character of language in the case of highly unconventional subjects, as a prelude to seeing why the major schools of clinical psychology as a whole adopt the narrow point of view when they make content attributions, as I'll explain in Section Three.

Unlike the *doppelgangers* and "counterfactual societies" and "twin Earthlings" who are usually discussed in the philosophical literature in connection with this issue, however, the cases I'll be discussing aren't just a philosophical fancy, since they involve children and schizophrenics – millions of very real but very young or very bizarre human beings who are a little bit out of sorts with the rest of us, but who often need to be understood and reached by us if we are to be of help to them. But why concentrate on cases of abnormal individual psychology, where the subjects' narrow content diverges so significantly from the wide content we may be tempted to assign to their attitudes and communications? The reason, of course, is that it's only here that the difference between narrow and wide attributions is really an issue. When we're dealing with normal subjects whose ideas coincide with their investigators', there ***is*** no conflict. It's only in the cases where subjects only partially understand or even misunderstand the content of the public language they may be using that the narrow and wide readings diverge, and as I shall be arguing, it's just here that we should ascribe to them the narrow content they ***do*** have – rather than the wide content they don't – in order to understand their behavior, whereas the externalists apparently recommend the opposite strategy.

The dispute, then, is over whether and when it's better to ascribe intentional content to subjects on the basis of a principle which attributes a store of "borrowed" knowledge from the experts and practices of society to them (as Putnam and Burge seem to recommend), versus being more sensitive to how individuals vary in how they use words and conceive of themselves and the world. But before proceeding any further, I should emphasize that my strategy for going about settling the dispute is to take a leaf out of the opposition's own book, by consulting the experts. After all, according to the dictates of their theory about the division of cognitive and linguistic labor, the common man (even if he is a philosopher) may have misconceptions, and to get to the heart of some matter, we must turn to the experts. So instead of relying upon armchair or lay intuitions about how to properly ascribe content, let's turn to the professionals who are in the business of attributing content and explaining individuals' behavior for a living, and see how they actually go about their business. As we will see, clinicians ***don't*** customarily try to attribute

content to subjects that doesn't reside within them in order to understand what they are thinking, but they ***do*** try to "get inside their heads," instead, by adopting the narrow point of view.

Understanding the Language and Thought of the Young

To understand children, it would be a dreadful mistake for developmental psychologists to interpret the words they are using conventionally, though they may be "part of the language" and have had a legitimate causal or social transmission up until this point. Instead of reaching for a dictionary, the investigator has to interpret children's words by carefully attending to their actual practices in order to try to reconstruct their intentions and conceptions. As we'll see, although there may still be some disagreements within the field of developmental psychology, it is clear that children present anyone who would understand them with an especially acute case of the *qua* problem we encountered in Chapter Two, and they have to be understood at their own level. Indeed, as Vygotsky (1962, p. 70) notes, the very word (almost), "quah," is implicated in a well-known and frequently cited example of the shifts in children's thought and word usage: first the child uses *quah* to designate

> ...a duck swimming in a pond, then any liquid, including the milk in his bottle; when he happens to see a coin with an eagle on it, the coin also is called *quah*, and then any round, coinlike object. This is a typical chain complex: Each new object included has some attribute in common with another element, but the attributes undergo endless changes.

As even this one example shows, there are a great number of problems with literal interpretations of children's speech: to begin with, a lot of what children say early on isn't really significant to them, it's merely what clinicians call "echolalia," which Vygotsky (1962, p. 83) describes as "nothing but empty verbalism, a parrotlike repetition of words by the child, stimulating a knowledge of the corresponding concepts but actually covering up a vacuum." Clearly, when children or schizophrenics engage in such behavior, there's no point in interpreting what they're actually saying. And after the babbling stage, when they do mean *some*thing by the words they're starting to use, very young children often don't speak anything close to complete sentences, and the investigator has to turn to the context in order to flesh out the intended communication.[94] Furthermore, even when their words partially share the same reference as ours, frequently they don't *mean* the same thing as the adults' do, as, e.g., Vygotsky notes.[95]

The problem, which Kasanin (1944b, pp. 42-43) outlines for us here, is that children are given to different ways of thinking before they learn to think and speak in our abstractions:

> In the development of thought in the child there are usually three stages, which follow in natural succession. The first stage is that of physiognomic thinking, in which the child animates objects and

[94] E.g., in reference to the work of J. Dore on children's speech acts, Gardner (1982, p. 165) writes, “When the child says "doggie," he is referring to the entire event rather than simply to the agent...investigators have ignored what the child is trying to do when uttering a word...through the use of intonations, the child expresses a variety of different pragmatic intentions, such as requesting, answering, demanding, or greeting. The child who says "doggie" when he is petting a dog may be labeling. When he says "doggie" with a rising intonation as the dog walks away he may be asking where the dog is going. And when he says "doggie" in a stern falling intonation, he may be ordering the dog to come to him.”

[95] E.g., see Vygotsky (1962, pp. 129-130), or this passage (from page 73): “Whether we say "the victor at Jena" or "the loser at Waterloo," we refer to the same person, yet the meaning of the two phrases differs....Using this terminology, we might say that the child's and the adult's words coincide in their referents but not in their meanings.”

> projects his ego into them....As the child becomes older he develops a type of thinking which is called "concrete thinking" and which is realistic and literal. In this stage of thinking, when the child says "table" or "chair" he does not mean tables or chairs in general, but the particular table or chair which is in his house or which belongs to him.

In what follows, we'll consider the significance of these and other deviations between children and ourselves and how they necessitate a narrow approach to psychological individuation and explanation.

The fact is, the child has to *learn* the adults' abstract categories, but that takes time. In the early stages, however, children are prone to a characteristic type of thought known as *syncretic* thinking, as Vygotsky (1962, pp. 60-61) explains in his "An Experimental Study of Concept Formation,"

> In perception, in thinking, and in acting, the child tends to merge the most diverse elements into one unarticulated image on the strength of some chance impression. Claparede gave the the name "syncretism" to this well-known trait of child thought...[which results from] a tendency to compensate for the paucity of well-apprehended objective relations by an overabundance of subjective connections and to mistake these subjective bonds for real bonds between the child's perceptions or impressions.

One child, for example, grouped the following disparate phenomena under the expression "Bow-wow": a barking dog, of course; a china doll; pictures of grandparents; a clock; cuff links; and a thermometer (Vygotsky 1962, p. 70). Similarly, Jean Piaget remarks in his ***Judgment and Reasoning in the Child***,

> ...to say that child thought is syncretistic means precisely this, that childish ideas arise through comprehensive schemas and through subjective schemas, i.e., schemas that do not correspond to analogies or causal relations that can be verified by everybody...For in the mind of the child everything is connected with everything else, everything can be justified by means of unforeseen allusions and implications.
>
> ...For instance, a child of 9 assimilates the proverb "White dust will ne'er come out of a sack of coal," to the corresponding sentence, "People who waste their time neglect their business." According to him, these two propositions mean "the same thing," because coal is black and can be cleaned. Similarly, people who waste their time neglect their children, who then become black and can no longer be cleaned...the tendency of the child to create comprehensive schemas in his imagination, and to condense various images into each other [is universal].
>
> Such then, is syncretism: immediate fusion of heterogeneous elements, and unquestioning belief in the objective interimplication of elements condensed in this way. Syncretism is therefore necessarily accompanied by a tendency to justify things at any price....The child can always find a reason, whatever may happen to be the question....(reprinted in Piaget 1977, pp. 103, 105)

Moreover, not only do children lump a number of things together into their own sorts of categories and justify them with their own tortured logic, but as a consequence of their egocentrism, they don't perceive objects in quite the same way as we do, either, as Piaget goes on to remark (on p. 113):

> ...the child's picture of the world is always moulded on his immediate, sectional, and personal point of view. Relations between things will therefore not be what is yielded by experimentation or fashioned by comparison of viewpoints; they will be what child logic and especially what syncretism makes them. By reason of the same cause which prevented him from adapting himself to other people, the child will fail to be adapted to the observation of the senses. He does not analyze the contents of his

> perceptions, but weighs it down with a load of previously acquired and ill-digested material. In short, he sees objects, not as they really are, but as he would have imagined them, if, before seeing them, he had *per impossible* described them to himself. This is why the early stages of children's drawings are not characterized by visual realism, i.e., by a faithful copy of the model in question, but by intellectual realism, such that the child draws only what he already knows about things and copies only an "inner model." Childish observation follows the same lines. The child often sees only what he already knows. He projects the whole of his verbal thought onto things. He sees mountains as built by men, rivers as dug out with spades, the sun and moon as following us on our walks. The field of attention seems to be wide in this sense that things are observed in large numbers, but it is narrow in the sense that things are schematized in accordance with the child's own point of view, instead of being perceived in their intrinsic relations.

As is well known, when we do examine children's egocentric ways of viewing how things in the world operate from their narrow point of view, one of the most striking characteristics we'll find is that they are prone to *animism*, i.e., to inappropriately attributing life and intentional states to objects which lack them. This results from their initial inability to distinguish the external world from themselves, as Piaget explains in ***The Child's Conception of Physical Causality***:

> ...the localization of the objects of thought is not inborn. It is through a progressive differentiation that the internal world comes into being and is contrasted with the external.... During the early stages the world and the self are one; neither term is distinguished from the other. But when they become distinct, these two terms begin by remaining very close to each other: the world is still conscious and full of intentions, the self is still material, so to speak, and only slightly interiorized. At each step in the process of dissociation these two terms evolve in the sense of the greatest divergence, but they are never in the child (nor in the adult for that matter) entirely separate. From our present point of view, therefore, there is never complete objectivity: at every stage there remain in the conception of nature what we might call "adherences," fragments of internal experience which still cling to the external world. (reprinted in Piaget 1977, p. 132)

As Piaget (1977, pp. 132-133) goes on to explain, he has identified five varieties of "adherences," so defined. To begin with, there are "feelings of participation accompanied sometimes by magical beliefs": e.g., "the sun and moon follow us, and if we walk, it is enough to make them move along." A second form is constituted by animism, "which makes the child endow things with consciousness and life." A third stage is "artificialism," where the child thinks "the things around him take notice of man and are made for man; everything about them is willed and intentional, everything is organized for the good of men." A fourth form is finalism or teleological thinking, such as when the child "says that the river flows so as to go into the lake." And finally, a fifth form centers around the idea of force: "things make efforts, and their powers imply an internal and substantial energy analogous to our own muscular force." The relevance of these various ways children's conceptions of the external adhere to their internalized and intentional model is that they affect not only their *verbal* behavior, of course (as when they are called upon to describe or explain how some machinery or process works), but they can also affect how they interact with the world: it explains why they talk to things, why they might run in front of a car (expecting it to stop of its own volition), and so on. It's useful for we caregiving adults to pay attention to such things, not only to make sense of their otherwise baffling behavior, but also to prevent injuries: sometimes, when we can't 'beat' their more primitive thinking, it's better to 'join' them, e.g., by impressing upon them that moving cars are *mean* and *like* to hit people that run on the streets without looking.

A related aspect of children's thought and how it diverges from our own is with respect to their conception of *death*. E.g., in her ***Conceptual Change in Childhood***, Susan Carey (1985, pp. 60-

64) reports that a review of the literature on the child's understanding of death reveals three characteristic phases. Children under five assimilate the notion to that of sleep and departure, i.e., as something which can be reversed if the subject chooses to, rather than as the cessation of all biological function, and they tend to view it as a sorrowful separation and/or as the ultimate act of aggression or punishment. In the second phase, in the early elementary school years, children understand that death is final, but they don't understand it in terms of a disruption of vital internal functions; rather, they see the causes as external, as due to "Father Death," e.g., or God, who comes for you when you have been bad. It is not until the final stage, by about age 9 or 10, that death is seen as an inevitable biological process which results when people stop breathing, for example. Once again, in order to understand and effectively cope with children's behavior surrounding the phenomenon of death, it is important to appreciate their conception of it. For one thing, in the early stages, children may not be sufficiently afraid of even the dangers they are told might kill them, because they may think that they can always come back from the grave; parents should try to impress upon them that this is false, or at the very least, they shouldn't assume that the child understands the objective dangers even if he agrees that some course of action could lead to death. For another, they may harbor a great deal of resentment against deceased relatives, whom they regard as staying away on purpose,[96] or they may attribute their staying away to their own failings. Parents need to understand such matters in order to help their children remember their loved ones with fondness, rather than resentment, and to circumvent problems to the child's self-esteem which could cause serious problems later on.

Finally, let's take one more aspect of children's thought that can be crucial to understanding their behavior, which concerns their moral conceptions. Here Piaget and Inhelder (1969, p. 126), for example, comment on the child's budding sense of moral realism in their ***The Psychology of the Child***:

> Moral realism leads to ***objective responsibility***, whereby an act is evaluated in terms of the degree to which it conforms to the law rather than with reference to whether there is malicious intent to violate the law or whether the intent is good but in involuntary conflict with the law. ...As a result, veracity is external to the personality of the subject...[and] a lie appears to be serious not to the degree that it corresponds to the intent to deceive, but to the degree that it differs materially from the objective truth. One of us set up the comparison of a real lie (telling your family you got a good grade in school when you weren't called on to recite) to a simple exaggeration (telling, after being frightened by a dog, that he was as big as a horse or cow). For young children, the first lie is not "naughty," because (1) it often happens that one gets good marks; and above all (2) "Mama believed it!" The second "lie," however, is very naughty, because nobody ever saw a dog *that* size.

This disregard of the intentions behind the rules makes many children moral absolutists at some stages, who regard not only moral rules but also rules to games as sacred and violable, as Piaget and Inhelder note,[97] and they can get quite upset if they or someone else has to break them. E.g., Piaget and Inhelder (1969, pp. 125-26) write,

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[96] As Carey (1985, p. 69) comments, "...the framework young children have for understanding human behavior [is] an *intuitive causality*, because it is based on intentional causality. Death, growth, eating, sleeping, breathing, the heart's beating...are all assimilated into this framework."

[97] E.g. see Piaget 1977, pp. 174-75); or Piaget and Inhelder (1969, p. 127): "...in games with rules, children before the age of seven who receive the rules ready-made from their elders (by a mechanism derived from unilateral respect) regard them as "sacred," untouchable, and of transcendent origin (parents, the government, God, etc.)."

> One of us observed a young child who was habitually subjected to a maternal order of no moral importance (to finish a certain part of the meal). When one day this order was waived by the mother herself because the child was indisposed, the child could not help feeling bound by the order and guilty for not respecting it.

Facts like these are relevant to evaluating children's behavior and deciding what to do next. For example, if your little girl is slapping her little brother, it makes a difference to how you should respond according to what her reasons are; was she just doing it from cruelty, or rather because she was punishing him "'Cuz he was bad," as she maintains? And if it was the latter, how important was the presumed infraction? Before you fly off the handle, you should reconstruct her reasons and see things from her point of view, if only to attempt to set her straight and prevent recurrences of the unwanted behavior.

But enough about understanding children, whose cognition clearly diverges from ours in important ways; now let's turn our attention to the problem of understanding schizophrenics.

Introduction to the Language Use of Psychotics

Like children, schizophrenics are living examples of the fact that the limiting case of a dialect (which the externalists place so much emphasis upon) is an idiolect, when speakers' communications can be so idiosyncratic that they're nearly unintelligible if we simply "take them at their word" as the externalist strategy suggests. Trying to keep up with an actual schizophrenic's speech can be quite an ordeal, as Norman Cameron (1944, pp. 54-55), for example, remarks, because it requires a "continual translation and sharpening of the focus that confuses and fatigues the listener. It gives the same feeling of strain that comes when one tries to follow a conversation in a foreign tongue with which one has some acquaintance but not quite enough." Of course, this isn't news, since the externalists themselves explicitly acknowledge that a certain degree of competence is required, and that some cases are so bizarre that a translation seems to be called for; however, we should quickly go over the problem of understanding schizophrenics and other psychotics, anyway, because it is instructive in pointing out why psychology sometimes needs to transcend the wide point of view.

There are a number of features of disordered schizophrenic speech. One of the things that goes wrong, as we'll see in more detail in Chapter Five when I respond to Stich's (1983) challenge whether schizophrenics can be understood in semantic terms at all, is that many schizophrenics are subject to "intrusive thoughts" related to their own obsessions, delusions, and episodes from their lives which break in on their consciousness and intermingle with the sentences they began.[98] Even when they don't interrupt themselves, schizophrenics sometimes use ***metonymy*** (referring to the whole of something by means of a part) and figurative speech to refer to things based upon aspects of events in their lives which commanded their attention: e.g., Cameron (1944, p. 54) remarks, "One patient says that he 'has menu three times a day' instead of food or meals," and Goldstein (1944, p. 27) notes that one hospitalized schizophrenic called his physician "le dance," because the interns skipped around him during rounds. A third problem is

[98] See, e.g., Cameron (1944, p. 56), and Harrow and Prosen (1978, 1979); such "intermingling" will be discussed in Chapter Five, Section 5.1.2.6.

that some schizo-phrenics, like many children, use ***neologisms***, which "carr[y] a lot of meaning – more than one ought to crowd into a word, particularly a word that nobody else understands" (as Sullivan [1956a, p. 331] puts it), and that meaning doesn't appear in any dictionary. Each of these problems requires the listener to get to know the subject better in order to make sense of his or her communications and decode the idiosyncratic references. But the problem which can hurt the arguments of Kripke, Putnam, and Burge most of all is that some psychotics are aberrant at the very juncture the externalists try to get their feet through the narrow intentional door – concern-ing both their use of general concepts and ***kind*** terms, and their unwillingness to ***defer*** to our way of conceptualizing the world, as I shall now explain in detail.

First, when schizophrenics *do* use general terms to refer to more than just their immediate experiences or surrounding (and there is some question about that[99]), do they mean what we mean by them? Investigators have found that this sometimes isn't the case, because some schizophrenics are like children in being prone to syncretic thinking, wherein they unite a number of objects with accidentally intersecting properties into a single category we would think of as an unnatural kind, such as the one Lakoff (1987) captures in the title of his ***Women, Fire, and Dangerous Things***. E.g., Von Domarus (1944) notes that one schizophrenic apparently believed that Jesus, cigar boxes, and sex were identical.[100] More systematic investigations of this phenomenon have found that a certain portion of schizophrenics and other psychotics are given to what Cameron (1944, pp. 56-57) has called ***overinclusive thinking***. Overinclusion, as Payne (1966, pp. 78-79) defines it, is characterized by "an inability to preserve conceptual boundaries, so that ideas which are only distantly related, or even irrelevant to a concept become incorporated into it, and are

[99] Some clinicians, such as Kurt Goldstein (1944, 1959) have suggested that some schizophrenics do *not* use general terms as general terms, since their ability to maintain the "abstract attitude" has been impaired, and their thinking is much more concrete, or "governed, to an abnormal degree, by the outer-world stimuli which present themselves to us, and by the images, ideas, and thoughts which act upon us at the moment" (Goldstein 1944, p. 23). However, Goldstein's views have encountered a good deal of criticism in the ensuing decades for various reasons, not the least of which are that tests purporting to measure it score almost *any* unusual response as "concrete," even if it was abstract (see Oltmanns and Neale [1978, p. 208], Harrow *et al*. [1972, pp. 436-37]), and they don't adequately discriminate between an impairment in abstractive ability and i) the susceptibility to the more dominant meanings of words, where this applies (see Maher 1972, p. 11), or simply ii) lower general intelligence (see Payne 1966, p. 81). However, the view that some at least schizophrenics have an impaired ability to think with abstract concepts had been defended by Wright (1975), who cites visual-verbal studies by Feldman and Drasgow in support: see M.J. Feldman and J. Drasgow, "A Visual-Verbal Test for Schizophrenia" (*Psychiatric Quarterly Supplement* 25, 1951, 55-64) and "Conceptual Processes in Schizophrenia Revealed by the Visual-Verbal Test" by J. Drasgow and M. Feldman (*Perceptual and Motor Skills* 7, 1957, 251-64) which involve tests requiring subjects to form abstract concepts to unite three out of four objects on each of 43 cards they are shown. Moreover, as we'll see in the text below, some more chronic schizophrenics have been found to be relatively underinclusive with their concepts. Further evidence is to be found in the fact that many schizophrenics and other psychiatric patients tend to give very literal-minded interpretations of parables such as "A rolling stone gathers no moss": see John D. Benjamin, "A Method for Distinguishing and Evaluating Formal Thinking Disorders in Schizophrenia" (in Kasanin 1944, 65 ff.), and a summary of further studies in Oltmanns and Neale (1978, pp. 213-17). However, when Harrow et al. (1972) distinguished concrete responses to proverbs from incorrect or bizarre abstract responses, they found that the difference between acute schizophrenic and non-schizophrenic patients fell just short of statistical significance, and that the scores for all the patients were low (averaging about 2 out of a possible 26 for the schizophrenics, and 1.5 for the depressives), hence their conclusion, "among acute patients in general, marked concreteness is relatively rare" (p. 437). However, as they go on to note, it may be a different story for chronically withdrawn, institutionalized, or understimulated schizophrenics.

[100] Von Domarus (1944, pp. 108-109) comments, “How did he arrive at that strange belief? Investigation revealed that the missing link for the connection between Jesus, cigar box, and sex was supplied by the idea of being encircled. In the opinion of this patient the head of Jesus, as of a saint, is encircled by a halo, the package of cigars by the tax band, and the woman by the sex glance of the man.”

regarded as a necessary part of it. Because of this, thinking becomes more abstract, less precise." This has been investigated by a number of means, including block-sorting tasks (which have subjects categorize according to several features at once, such as shape and/or color and/or volume); object-sorting tasks (where subjects are asked to hand over familiar objects of the same kind as the target, such as cigars, pipes, or match-boxes); and card-sorting tasks (where subjects are to separate cards into two piles – those depicting objects in the same category as the target [e.g., fruits], and those which do not, though some of these show similar, distracting items [e.g., vegetables]). In the block-sorting tests, rather than sticking to just the salient features such as shape, weight, or hue, some schizophrenics apparently regard data such as scratches on the objects, or shadows cast by them, or their personal associations with them as relevant to the classifications (see Payne 1966, p. 79). In the object-sorting tasks, some schizophrenics bring in all sorts of objects from outside the test which don't even remotely belong to the intended set, such as desk-blotters, the tester himself, or objects from another room (see Cameron 1944). And in the concept-attainment tests, studies have found that schizophrenics tended to make more errors than normals did in including members of the second, similar category, thus forming a broader category than the one intended.[101] Similarly, in a synonym test administered by Moran,[102] schizophrenics gave more imprecise synonyms than did normals, and they underlined more distantly related words (e.g., head, legs, table...) when asked to indicate which ones were essential to the concept or object denoted by the stimulus word (e.g., man); these results were confirmed by Epstein.[103]

For an illustration of the phenomenon of overinclusiveness, consider this passage from Andreasen (1979, p. 1320); although she offers it as an example of illogicality, it seems to indicate a conceptual difference the more the patient elaborates:

> Parents are the people that raise you. Any thing that raises you can be a parent. Parents can be anything, material, vegetable, or mineral, that has taught you something. Parents would be the world of things that are alive, that are there. Rocks, a person can look at a rock and learn something from it, so that would be a parent.

Thus, if this patient were to indicate a local boulder and comment on how much he has learned from that particular 'parent,' we would do well to take his conception of "parent" into account if we are to comprehend him adequately.

As for the extent of this phenomenon, by no means does it occur or persist in every schizophrenic, but nor is it limited to schizophrenics alone. Payne (1966, p. 95; 1973, p. 462) himself reports that several of his experiments did ***not*** show that schizophrenics as a group were more overinclusive than non-schizophrenics, and he concludes that it is a relatively rare disorder which is found in between 30 and 50 percent of acutely ill mental patients who are diagnosed as schizophrenic, and he also remarks that in most cases it clears up within a month or two. Harrow *et al.* (1972a), however, dispute the latter claim: despite a significant improvement on conceptual

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[101] E.g., see L.J. Chapman and J.A. Taylor, "The Breadth of Deviate Concepts Used by Schizophrenics" (*Journal of Abnormal and Social Psychology* 54, 1957, 118-23), summarized in Payne (1973, p. 455).

[102] See L.J. Moran, "Vocabulary Knowledge and Usage Among Normal and Schizophrenic Subjects" (*Psychological Monographs* 67, 1953), summarized in Reed (1970, p. 411).

[103] See S. Epstein, "Overinclusive Thinking in a Schizophrenic and Control Group" (*Journal of Consulting Psychology* 17, 1953, 384-88); both Reed (1970, p. 411) and Payne (1973, p. 452) note that Epstein's results confirm Moran's.

overinclusion scores overall for classical schizophrenics from an average of 3.18 (out of a possible 5 on their scale) during the acute phase to 2.61 seven weeks later (when most patients attain at least partial remission), they found that 12 of the 28 schizophrenics still exhibited high degrees of conceptual overinclusion at that time. This was down 6 from the 18 who were in the high range at the acute phase, but it is still a "relatively large" percentage, as they note (on p. 61).[104] Other investigators, however, such as Feinberg and Garman[105] have found that chronic schizophrenics were actually more underinclusive, and Andreasen and Powers (1974) also found that the concepts of schizophrenics who have a history of incomplete remission between episodes and who lack any mood disturbance are less inclusive than those of normals. These findings are consistent with reports by Venables (1964) and others that the focus of acute schizophrenics' attention is overly broad (such that they bring in things from both the inside and the outside which aren't relevant to the immediate task or situation), whereas the focus of attention of more chronic schizophrenics is overly restricted (such that they don't bring relevant items in memory to bear upon a situation, and fail to consciously register many peripherally present stimuli), possibly as the result of their attentional "filter" having been so overwhelmed earlier.[106] What does seem clear is that this tendency to overinclusion only appears to occur in patients who are severely psychotic, and not in those with a lower degree of pathology (e.g., see Davis and Blaney, 1976), and that it is not restricted to schizophrenics alone. E.g., Andreasen and Powers (1974) found that overinclusion is more prevalent in manics than in normals or schizophrenics; consequently, they suggest that many of those patients who tested positive for it in earlier studies were probably schizoaffectives (i.e., subjects with psychotic symptoms such as delusions or hallucinations who are also manic or depressed), rather than more rigidly defined schizophrenics, and Payne (1973, p. 473) concurs that many of the subjects in his studies may have been schizoaffectives. However, it doesn't matter to our purposes here precisely *which* population of psychotics is prone to the problem: the point is, *some* patients do overextend normal conceptual boundaries in some circumstances, and that may impair our understanding of them – unless we are prepared to give up conventional interpretations of their terms and become more sensitive to the way they are actually using them. Moreover, the fact that some patients may be *under*inclusive relative to our concepts (such that they don't hand over all the ash-trays in

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[104] Harrow et al. (1972a) account for the discrepancy between their findings on the persistency of overinclusion and Payne's in terms of the fact that their measure of conceptual overinclusion was more sensitive than the latter's behavioral measure: instead of simply counting how many objects were handed over (which can vary as a function of the chronic patients' motivational level), their scorings were based upon the subjects' actual sorting principles, *viz*., "(a) attempting to force-fit an object into a chosen dimension of the starting object [SO] which does not really belong in that dimension (e.g., for *SO: red paper circle* – using the category "round" and sorting spoon, pliers, and candle as "roundish") (b) using a vague, more distantly related concept as a categorizing principle when there are obviously closely related and more relevant concepts available (e.g., for *SO: pipe* – sorting objects which can burn); (c) arbitrarily changing starting points in the midst of sorting and using one of the already sorted objects as a basis for subsequent sorting (e.g., for *SO: fork* – sorting knife and spoon as silverware, then focusing on the *knife*, thereafter sorting objects which can be cut); and (d) using several dimensions of the original starting object without seeming to recognize that each dimension is discrete (e.g., for *SO: sink stopper* – sorting in hit and miss fashion the fork, pliers, plate, and lock, with the implied categories, "items washed in sink" and "metal objects," not clearly stated)." (from Harrow *et al*. 1972b, p. 164

[105] See I. Feinberg and E.M. Garman, "Studies of Thought Disorder in Chronic Schizophrenia" (*Archives of General Psychiatry* 4, 1961, 191-201), cited in Reed (1970, p. 412).

[106] This theory about the presumed defect in the "filtering" of attention, which is usually attributed to D.E. Broadbent (*Perception and Communication*. Oxford: Pergammon Press, 1958) originally, has been forwarded by Payne (1966), Maher (1972, 1983), and many others to account for the shift in schizophrenics' cognitive performance over time.

an object-sorting task, e.g.) just makes the same point (i.e., that not all subjects associate the same extension with a kind term) from a different direction.

That brings us to the second point relevant to the externalists' scheme, which is that some psychotic patients not only fail to latch on to their investigators' principles of categorization, but they are not especially willing to ***defer*** to the conceptual schemes of the authorities they vary from, either. This was also noted by the early investigators who tested them on concept-formation tasks; e.g., Cameron (1944, p. 55) comments, "It is often striking how well satisfied many of them are with their very inadequate communication, showing little or no evidence of concern over its unintelligibility. They either fail to recognize that you are having trouble or they are haughty about your stupidity." And Kasanin (1944, p. 43) remarks,

> The schizophrenic...frequently develops other principles and other classifications than those which the average person adopts. Even more important is the fact that even when the principle upon which the classification is based is explained to the schizophrenic, he frequently refuses to use it and maintains his own classification, for which no general principle can be adopted. He puts the most heterogeneous blocks together, stating that they belong together because they are "all policemen" or "all little people," although they are dissimilar in all aspects so far as can be seen by the normal person.

That takes us to a more general problem with schizophrenics' verbalizations which investigators have commented on: many schizophrenics are either unwilling or unable to put themselves in the role of the listener to edit or modify their own speech accordingly.[107] If they won't or can't come to us by adopting our perspective when they attempt to communicate with us and tailoring their speech accordingly, then we must come to them by learning about them.

In sum, then, "The primary purpose of language – communication – is so impaired in the schizophrenic that his language becomes highly individualistic and can be understood only by those closest to him and those who have a deep understanding of him," as Sullivan (1944, p. 15) puts it. Sometimes the conceptual boundaries of psychotics are either more broad or more narrow than is normal, sometimes episodes and conflicts in their lives keep intruding into their speech, and sometimes they make highly ambiguous and idiosyncratic references. (I will be returning to these themes in Section 5.1.2.6.) In these cases, we're not going to get very far by cleaving to a conventional interpretive mode; instead, we have to make a real effort to get to know the subject better and adopt their point of view.

This isn't just the case with young children and full-fledged psychotics, either. To start with, it's also true for those with more intermediate disorders, such as the schizotypal personality

[107] E.g., see Sullivan (1944, 14-15) for his account of the defective "fantastic auditor" in schizophrenics checking their utterances for adequacy, or Cameron (1944, p. 55), or a number of more recent investigators who have taken up the idea and called it a problem in "self-editing" or "impaired perspective," including Harrow, Lanin-Kettering, and Miller (1989); Davis and Blaney (1976); Bertram Cohen et al. (e.g., see B. Cohen, G. Nachmani, and S. Rosenberg, "Referent Communication Disturbances in Acute Schizophrenia," *Journal of Abnormal Psychology* 83, 1974, 1-13; or B.D. Cohen, "Referent Communication Disturbances in Schizophrenia," in Schwartz 1978); or D. Rutter (see his "Language in Schizophrenia: The Structure of Conversations," *Bulletin of the British Psychological Society* 35, 30 ff.). As Rutter (1982, p. 613) puts it, "Schizophrenic patients whose language is disturbed find it difficult to take the role of the listener and fail to structure what they say in a way that is easy to follow and reconstruct. Their disturbance lies not in regulating and organising (sic) their thoughts, but in expressing and communicating them."

disorder.[108] But that's only the beginning, because schizophrenics and children aren't so different from the rest of us – we all started out with an individualistic language, and it persists to one degree or another, as Sullivan (1944, p. 10) points out here, adding that normals' speech sometimes seems to regress to unintelligibility so far as third parties are concerned:

> In a word, language always starts as an entirely autistic performance. We hear our parents utter certain phonetic combinations and they appear to us in terms of the situation in which we hear them. If, for example, one hears "mamma" only when suffering from rebuff, "Mamma" for a long time in one's life has an extraordinarily unpleasant connotation. If, however, one hears "mamma" only as an aftermath to the disappearance of all tension, then "mamma" for a long time will have many of the attributes which we later associate with the perfection of heaven. We all start out with a highly individuated language, a set of purely autistic phonetic combinations.
>
> When one is able to relax all vigilance against one's fellows, language similarly regresses toward its beginning. We do not need to become primitive in order to become simple. The safer we are with our fellows, the simpler and also more autistic becomes our operation with language symbols. This is so much so that very old friends say singularly unimportant words to each other and understand each other perfectly....

Similarly, some have suggested that Richard Nixon and other Watergate conspirators exemplified psychotic speech in the famous tapes, but Walter Weintraub (1982, p. 614) remarks that, "A close reading of the Watergate transcripts indicates that none of the participants had the slightest difficulty understanding the others,"[109] and he elaborates on the example to both explain the problem of idiosyncratic speech and generalize it to others:

> [The individuals involved]...shared certain assumptions and knowledge about the subjects under discussion...[and] had no need to provide each other with explanations and clarifications that a stranger would need. Most conversations among family members and friends tend to be rambling and difficult to follow.
>
> As Schwartz [1982] points out, schizophrenic speakers tend to assume that their listeners know more about them than they actually do. This assumption contributes to the mysterious quality of schizophrenic speech. To be sure, schizophrenics are not alone in making this assumption. Children and certain ethnocentric adults often address strangers as if they were relatives or friends.

To some extent, then, many of the rest of us lapse into our own vocabulary at times, and "have our own take on things" and live "in a world of our own." Since our behavior arises from these inner worlds and intentions, rather than from what the surrounding textbooks and dictionaries say our words should mean, the former are the target of individual psychology's inquiry when attempting to understand our behavior. As we'll now see, the major schools of clinical psychology recognize this, which is why they explicitly adopt a narrow point of view.

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[108] "The clinical features of a schizotypal personality," as George Valiant and J. Christopher Perry note (in their "Personality Disorders," in Kaplan and Sadock [1985, p. 972], my emphasis), "...represent the borderline between schizoid personality and schizophrenia. In schizotypal personality disorder, perceiving, thinking, and communication are disturbed. Like schizophrenics, schizotypal personalitites may not know their own feelings, yet they are exquisitely sensitive to detecting the feelings of others, especially such negative affects as anger. They may be superstitious or claim clairvoyance. Their inner world may be vividly peopled by imaginary relationships and filled with child-like fears and fantasies. They may believe themselves to have special powers of thought and insight, or claim unusual mystical, religious, or philosophical experiences. Although frank thought disorder is absent, their speech may often require interpretation. This is due to unusual usages of words and metaphors or to the ambiguous meanings that they apply to everyday terms and ideas."

[109] See Walter Weintraub, *Verbal Behavior: Adaptation and Psychopathology* (New York: Springer, 1981), which analyzes the Watergate transcripts in detail.

Clinical Psychology and Notional Worlds

Now that we've been introduced to some of the idiosyncrasies in the notional worlds and patterns of communication of some of the people in their problem domain, we should turn to the major schools of clinical psychology, to see how they go about understanding and explaining their clients' problems. First, we'll review the type of model of the mind they subscribe to, and then see how they advocate taking their clients' narrow point of view in order to understand their behavior.

Although the phrase "notional world" may be recent, the idea of a person-centered world internal to the subject is probably as old as the distinction between appearance and reality. We'll begin by exploring the notions forwarded by a number of recent clinical psychologists and psychiatrists who are representative of the field, including the "phenomenal fields" of the phenomenological psychologists Donald Snygg and Arthur Combs, the "experiential worlds" of the Humanistic psychologist Carl Rogers; the "personal constructs" of George Kelly; the "assumptive worlds" of the more eclectic psychologists H. Cantril, C. Murray Parkes, Jerome Frank, and others; and the concept of the "representational world" which emerges in the Freudian corpus.[110]

Although there are some differences between them which aren't particularly germane to this discussion, the core assumption of these models is their mentalism, which explains why we vary in the way we respond to the world. Rogers (1951, pp. 484-85), for example, comments on this theme:

> I do not react to some absolute reality, but to my perception of this reality. It is this perception which for me ***is*** reality. Snygg and Combs give the example of two men driving at night on a western road. An object looms up in the middle of the road ahead. One of the men sees a large boulder, and reacts with fright. The other, a native of the country, sees a tumbleweed and reacts with nonchalance....Two individuals listen to a radio speech made by a political candidate about whom they have no previous knowledge. They are both subjected to the same auditory stimulation. Yet one perceives the candidate as a demagogue, a trickster, a false prophet, and reacts accordingly. The other perceives him as a leader of the people, a person of high aims and purposes.

Common to the accounts is the idea that we *are* acting according to internal notions and scripts, not just responding to things in unstructured ways. Kelly's Personal Construct Theory[111] is a clear instance of this, as Bourne and Eckstrand (1976, pp. 341-342) note:

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[110] See, e.g., Rogers (1951, 1960); Parkes (1971); Sandler and Rosenblatt (1962); or Spiegelberg (1967), for a brief overview of these approaches. Rogers himself, however, whose views we'll be discussing extensively in the text, was innocent of actually studying academic phenomenological philosophy – it's more of a case of a fortuitous parallelism and mutual corroboration; e.g., see Spiegelberg (1972, p. 150), or as Rogers puts it in his autobiography (reprinted in Spiegelberg [1972, p. 156] and E.G. Boring's *A History of Psychology in Autobiography, V* (1967, p. 378), "I was surprised to find, about 1951 that the direction of my thinking and the central aspects of my therapeutic work could justifiably be labeled existential and phenomenological. It seems odd for an American psychologist to be in such strange company. Today these are significant influences on our profession." As we'll see in Part II, Rogers came to his experiential model through clinical experience, beginning with children, and that experience has demonstrated the model's utility.

[111] See George Kelly's ***The Psychology of Personal Constructs*** (New York: Norton, 1955).

> Kelly's theory is extremely complex, but it is based on the single fundamental assumption that human behavior is determined by what he calls ***personal constructs***, or ways of predicting the world [e.g., 'all women are hostile']. In other words, Kelly believed that individuals act in accordance with their own unique set of expectations about the consequences of their behavior....For Kelly, human behavior is not "pushed or pulled" by instinctual desires, external reinforcement, or response tendencies, but instead reflects each individual's attempts to make sense of the world as he sees it.

The basic idea of such models, then, is that we are moved by our experiences. This *should* seem and common-sensical, because it describes our everyday mental life and its effects. At the same time, it has profound import, because it maintains both that we *have* a meaningful mental life (*pace* some guises of Eliminative Materialism, to be discussed in Parts II and III), and that we are not moved by the external environment *directly* (as in a reflex), but rather by our conceptions or representations of it, which mediate our responses. According to this framework, our thoughts have effects, and they have the effects they do because of the kinds of thoughts they are. In other words, ***content matters***: we refrain from some activities because we think they'll be too hard or too dangerous; we engage in others because we think they'll help us get what we want, or ward off what we don't want.

These types of models, which are common to the "Existential," "Humanistic," "Phenomenological," "Cognitive/Behavioral," and "Psychodynamic" schools of psychotherapy alike,[112] have two main aspects. First, there is the ***phenomenal field*** as a whole, the set of expectations and interpretations through which we interpret stimuli which constitutes reality as the person experiences it. As Spiegelberg notes,

> It is defined as "the entire universe, including himself, as it is experienced by the individual at the instant of action." As such it is contrasted with the "objective physical field." More specifically, the field is identified with "the universe of naive experience in which the individual lives, the everyday situation of self and surrounding which each person takes to be reality."[113]

This can be readily parlayed into notional world terms: a phenomenal field is a time-slice of a subject's notional world – it's all the things the person believes in (or wants, etc.) at the time of acting. Jerome Frank (1961, pp. 20-21) terms it the person's "assumptive" world:

> In order to be able to function at all, everyone must impose an order and regularity on the welter of experiences impinging upon him. To do this, he develops out of his personal experiences a set of more or less implicit assumptions about the nature of the world in which he lives, which enables him to predict the behavior of others and the outcome of his own actions. The totality of each person's assumptions may be conveniently termed his "assumptive world."
>
> This is a short-hand expression for a highly structured, complex, interacting set of values, expectations, and images of oneself and others, which guide and in turn are guided by a person's perceptions and behavior and which are closely related to his emotional states and feelings of well-being. Assumptions range widely in scope. An example of one extreme would be assumptions connected with the importance of brushing one's teeth; of the other, those concerning the nature of God.

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[112] Even "Interpersonal" psychiatrists such as Harry Stack Sullivan acknowledge internalized notional worlds in practice: e.g., see his (1954, pp. 130, 168). I'll be discussing the possible challenges to individualism posed by the Interpersonal and "Object Relations" approaches in more detail in Section 3 below.

[113] Spiegelberg (1967, p. 234), quoting Snygg and Combs, *Individual Behavior: A New Frame of Reference for Psychology*, New York: 1949, p. 15. Incidentally, Combs began as one of Rogers' students (see Spiegelberg 1972, p. 152).

This internalized representational world which constitutes reality as the agent conceives of it is constructed by his or her ego to adapt to the external world (e.g., see Sandler and Rosenblatt 1962, p. 136), but there can actually be a great deal of slippage between the way things 'really' are and how they seem to us – a lack of fit that in many cases we call "abnormal psychology."

This is particularly true when it comes to the ***phenomenal self*** or ***self-representation***, which is the portion of the phenomenal field that "includes all those aspects...which the individual experiences as part or characteristic of himself," as Snygg and Combs note,[114] the parts the individual identifies as the "me" or "I". In other words, the phenomenal self is the central protagonist of a person's notional world to whom the *de se* attitudes are self-ascribed.[115] The problem is, sometimes people can become ***too*** self-centered,[116] and also ***off***-centered,[117] and their sense of self – the way they define and identify with their own character – can go seriously awry, such as when they think they are Christ, or a worthless piece of dung, or both,[118] or when they become dissociated and depersonalized and no longer think they're really a person at all.[119]

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[114] Snygg and Combs (*op. cit*., p. 78), quoted in Spiegelberg (1967, p. 234).

[115] *Cf.* Sandler and Rosenblatt (1962, p. 134), who are working within the psychoanalytic tradition:
"The construction of the representational world is a product of ego functions, and the self- and object representations are part of the representational world...[which] might be compared to a stage set within a theater. The characters of the stage represent the child's various objects, as well as the child himself. Needless to say, the child is usually the hero of the piece. The theater, which contains the stage, would correspond to aspects of the ego, and the various functions such as scene shifting, raising or lowering the curtain...would correspond to those ego functions of which we are not normally aware."

[116] On the narcissistic personality, see, e.g., George Valiant and J. Christopher Perry, "Personality Disorders," in Kaplan and Sadock (1985).

[117] E.g., the existential psychologist Rollo May (1964, pp. 173-74) even goes so far as to diagnose neuroses as off-centeredness here: "When a patient comes in and sits down in the chair opposite me in my consulting room, what can I assume about him? I shall offer some principles which have been helpful to me. *I assume that this person, like all beings, is centered in himself, and an attack on this centeredness is an attack on his existence*. He is here in my office because this centeredness has broken down or is precariously threatened. Neurosis, then, is seen not as a deviation from my particular theories of what a person ought to be, but precisely as the method the individual uses to preserve his own centeredness, his own existence. His symptoms are his way of shrinking the range of his world in order that his centeredness may be protected from threat; a way of blocking off aspects of his environment that he may be adequate to the remainder."

[118] See Rokeach (1964) for a description of a subject who thought he was <u>both</u> Christ *and* a piece of dung, whose homosexual encounters as a boy and confused sexual identity were probably contributing factor to his extraordinary views about who he was (pp. 324-26).

[119] To ease the reader into an understanding of dissociated or depersonalization disorders, consider the Warner Bros. cartoon in which a little Indian Chief says, "Me smell Mohican burning. Me last Mohican. Yeow! me must be burning!" We don't usually think this way – we rarely proceed by deductive inference, and we have a much more immediate sense of self. We'd not only feel the pain, but we'd also recognize it *as* pain – as ***our*** pain. But some don't. Just as some are dissociated from parts of their anatomy because of neurological damage (e.g., see Sacks [1985, pp. 53-55] for a description of a man who thought the leg attached to him was a cadaver's), some are in the same position with regard to their attitudes and personalities – they disown parts of themselves and no longer recognize that aspects of their phenomenal field are indeed part of their phenomenal self. When the person's notional world becomes off-center in this manner, and the subject no longer identifies with his experience but is the passive recipient of them, clinicians call it depersonalization, as L. Dugas and F. Moutier explain in their "La Depersonnalisation" (quoted in translation in Nemiah 1985, p. 955):
"Consider a person in the ordinary circumstances of life: He receives the sensory impressions of objects, marshals his memories, recalls images, forms and combines idea, judges, reasons, caries out actions, is affected by pleasure and pain; he is aware of all these and of their connection with himself. Suppose that the same person experiences identical states, but ceases to have an awareness of them as being his own; he will witness "his life as performance presented by

And finally, it should be noted that although our personal constructs, phenomenal fields, or assumptive worlds represent everything one experiences and believes in at any given time, these experiences are not all consciously attended to. As Frank (1961, p. 21) explains, there are ***levels*** of awareness:

> Different parts of the assumptive world exist at different levels of consciousness. Only a minute part of it is in awareness at any one time, and the relative accessibility to awareness of different aspects of it may differ greatly. A person may be clearly aware of his assumptions about the nuclear arms race, let us say, but be oblivious of his assumption that he must be perfect in order to gain his mother's love. Yet the latter conviction may have considerably more effect on his behavior than the former. Unconscious assumptive systems are especially pertinent to psychotherapy, not only because they are of profound importance to personal functioning but because...they resist change.[120]

Psychotherapists are needed not only to bring such maladaptive unconscious assumptions to the surface, but also to help alleviate the distress that can result when there are serious inconsistencies among one's assumptions;[121] this is particularly true when the inconsistencies pertain to one's self, because self-esteem is at the very fountain-head of behavior, and as a consequence one of the most important and basic dynamics of our phenomenal field is the urge to preserve and enhance our image of the phenomenal self.[122]

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another"; he will continue to perceive sensations, colors and forms, touches, smells, etc., but it will seem to him that these sensory impressions do not affect him or reach him any more. He will continue to have memories, but it will appear to him that the past they recall escapes him and is no longer his own. He will still think, reason, act, even be moved by feeling, but it will seem to him that it is not he who thinks, reasons, acts or feels pleasure and pain. Although nothing in his life will be different, yet everything about it will appear changed. He will no longer know himself, will be amazed that he is still alive, and will be outside of his experiences."

As the DSM-III (1980, pp. 259-60) points out, depersonalization is sometimes implicated in disorders such as schizophrenia, affective disorders, anxiety disorders, and personality disorders. Here we get a curious empirical validation of Kant's dictum that "It must be possible for the 'I think' to accompany all my representations" (*The Critique of Pure Reason* B 132), as well as evidence that the *de se* account of self-ascription is not just a logical contrivance to accommodate indexicals. When people no longer identify with a self and no longer *self*-ascribe the properties of living in a certain kind of world, the condition can be most distressing, as Nemiah (1985, p. 955) notes: "The experience of depersonalization is often accompanied by considerable secondary anxiety, and frequently, patients fear that their symptoms are a sign that they are "going insane." It is a curious paradox that, even though patients complain of being emotionally dead and estranged, they are capable of being emotionally upset by that very sense of loss. Indeed, all the manifestations of depersonalization are acutely unpleasant; they not only motivate patients to seek medical help but also often drive them to vigorous activity or to inducing intense sensations in themselves in order to break through the prison walls of their sense of unreality.

[120] Most therapists recognize levels of awareness, including unconscious processes. Apart from Freud, of course (e.g., he says that the task of psycho-analysis is "to make conscious everything that is pathogenically unconscious," in *Introductory Lectures on Psycho-Analysis* (1916-17, Lect. 18: "Fixation to Traumas – The Unconscious," in **SE** XVI, p. 282), there's also the humanistic psychologist Rogers (see his 1951, p. 438; or his interview in Evans [1976, p. 215]); and the cognitive-behavioral therapists Aaron Beck (whose "Cognitive Therapy" we will examine in Chapter Seven; see Beck (1976), pp. 30-34, 318) and Albert Ellis (1971, pp. 1-2), who states that his RET therapy "not only quickly reveals to the individual many important things of which he is, at best, only dimly aware, but it almost immediately begins to undercut and disembowel the conscious and unconscious irrational assumptions that make him and keep him emotionally disturbed."

[121] E.g., see Frank (1961, p. 21) or Rokeach (1968, p. 181) on this function of psychotherapy.

[122] See Rogers (1951, pp. 503-16); or Adler (1930). Adler's theory that many of us are victimized by our own *inferiority complexes* is now part of the popular parlance. In his view, neuroses are due to such *misconceptions* as erroneous feelings of superiority or inferiority (see Adler (1930); or Bourne and Eckstrand (1976), pp. 328, 330); once the problem areas are identified, the therapist must set about rectifying our faulty reasoning, by *correcting* us. *Cf.* Karen Horney (1950, *passim*, e.g., p. 374) who urges that we have to get patients to realize that their self-loathing is often due

That, then, is the basic model that clinicians working within the notional world paradigm work with; as we'll see now, it provides the rationale for adopting a *narrow* perspective when it comes to understanding and explaining the behavior of individuals. Carl Rogers' ***Client Centered Therapy*** (1951), for example, is a seminal text in this tradition that clearly expresses how the goals and aims of psychotherapy follow naturally from the phenomenal field or notional world framework: since the self is the center of experience (p. 483), and since we react to the world as it is experienced (484), the best vantage point to understand behavior is from the subject's own point of view (494-95), in order to discern how the self is organized (29-30). The main role of a therapist or counselor, then, is to become "a genuine alter ego" (40) who can assume the *clients'* (rather than the "patients'"[123]) point of view "gain the center of [their] perceptual field, seeing through the client's eyes" (32), in order to help them gain insight into aspects of their personality that they may resist seeing and to come to a better understanding and acceptance of themselves. As Rogers puts it (on p. 40),

> ...it is the counselor's function to assume, in so far as he is able, the internal frame of reference of the client, to perceive the world as the client sees it, to perceive the client as he is seen by himself, to lay aside all perceptions from the external frame of reference while doing so, and to communicate something of this empathic understanding to the client.

And as Spiegelberg (1972, pp. 151-52) comments,

> ...Rogers' final theory of personality and behavior states even more explicitly that the phenomenal field is an essential part of the structure of the person; it is the world to which the individual reacts, in this sense "reality." This makes it clear why Rogers took an intense interest in the description of the phenomenal world, though thus far only as it was described by the client himself. Thus the phenomenological world was not only the main causal factor for man's behavior but was also the main point of attack for the therapeutic process.

Of course, Rogers isn't alone in taking this view. The self-professed phenomenologist Buytendijk (1967, p. 359) also submits that psychological investigations only really begin

> ...when one is free to look for "the pure inner life considered as the source of all significance and valuation"... one should place in the center of attention the *mode* in which the subject relates himself to the environment, that is, *how* he is aware of the situation, *how* he understands the phenomena, *what* they mean to him and *how* he values them.

Similarly, Freud distinguishes between the ***material*** reality we all deal in (which includes the events a patient has "really" experienced) and the ***psychical*** reality of the patient (which includes whatever he or she *thinks* has happened to them, some of which may be utter fantasy), and he remarks,

> It remains a fact that the patient has created these phantasies for himself,[124] and this fact is of scarcely less importance for his neurosis than if he had really experienced what the phantasies contain. These

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to inflated, perfectionistic neurotic pride. Such views are precursors to what is today called the "Cognitive Theory of Depression," which will be discussed mainly in Chapter Seven, but see also my discussion of Ellis in Chapter Four.

[123] Unlike all-knowing Freudians who regard subjects as "patients" driven by psychological determinants who must be "treated," Rogers views them as clients, as individual persons who are directed by their own attitudes and who are in need of the humble therapist's services.

[124] Such phantasies as secret death-wishes against loved ones (see last note), or childhood seduction "phantasies" which Freudians explain away as Oedipal (actually, Electran) erotic wishes they feel guilty about – see next note.

> phantasies possess ***psychical*** as contrasted with ***material*** reality, and we gradually learn to understand that ***in the world of neuroses it is psychical reality which is the decisive kind***. [125]

The object of psychological inquiry, then, is the subject's "psychical reality" or notional world, particularly in neuroses, where

> ...what determines the formation of symptoms is the reality not of experience but of thought. Neurotics live in a world apart...only 'neurotic currency' is legal tender; that is to say, they are only affected by what is thought with intensity and pictured with emotion, whereas agreement with external reality is a matter of no importance.[126]

Thus, the objective of analysis or therapy is to uncover the individual subject's view of him or herself and the world; since behavior is structured and caused by the individual's conceptions, they are the proper objects of clinical inquiry, explanation, and intervention, however idiosyncratic they may be. I shall be explaining *how* clinical investigation and intervention proceeds in more detail in Parts II and III, but first, let's consider some objections to individualistic psychology that may arise from within clinical psychology itself.

On the Non-Individualistic Elements in Clinical Psychology

So far my argument in favor of individualistic psychology has been confined to the importance of using empathy to assign narrow content in order to understand individuals' behavior in clinical settings, but it may be objected that I have neglected to take into account a number of external factors whose importance have been explicitly recognized by clinical psychologists or even actually built into their methodology. Consequently, I should now address myself to some of these anti-individualistic concerns about factors other than intentional content, in order to set the record straight about what both narrow psychology and myself are committed to. To begin with, I will consider a few preliminary concerns clinical psychologists might have if they misunderstood just what an individualistic psychologist is advocating, and then I'll concentrate on the more serious problem of understanding how narrow psychology is to accommodate such

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[125] Freud's's Lecture 23, "The Paths to Symptom-Formation" (in **SE** XVI, p. 368). *Cf.* his *General Introduction to Psychoanalysis* (New York: Liveright, 1920, p. 321). I should note in passing, however, that this strain in Freud's thought emphasizing the importance of phantasies came *after* he gave up the ***seduction theory*** of 1896 (in "The Aetiology of Hysteria," ***SE*** III', pp. 191-221; reprinted in Masson 1985), which held that actual (as opposed to imagined) sexual episodes in childhood are responsible for disturbances, apparently due to a reluctance to believe that incest was so rampant in 'civilized' societies. This is a case of someone adopting the right theory (narrow psychology) for the wrong reasons (denial). See my Appendix B for more on Freud's failings.

[126] See Freud, *Totem and Taboo* (1913), Chapter III: "Animism, Magic, and the Omnipotence of Thoughts" (**SE** XIII, pp. 86-87). He says similar things in "Formulations on the Two Principles of Mental Functioning" (1911) (in **SE** XII, pp. 218, 225). Regarding the importance of narrow content, the *Totem* passage quoted in the text continues: "What hysterics repeat in their attacks and fix by means of their symptoms are experiences which have occurred in that form only in their imagination – though it is true that in the last resort those imagined experiences go back to actual events or are based upon them. To attribute the neurotic sense of guilt to real misdeeds would show an equal misunderstanding. An obsessional neurotic may be weighed down by a sense of guilt that would be appropriate in a mass-murderer, while in fact, from his childhood upwards, he has behaved to his fellow-men as the most considerate and scrupulous member of society. Nevertheless, his guilt has a justification: it is founded on the intense and frequent death-wishes against his fellows which are unconsciously at work in him. It has a justification if what we take into account are unconscious thoughts and not intentional deeds."

matters as the relevance of external events and other people to our behavior and to psychiatric practice.

To begin with, I'm ***not*** an individualist to the point of claiming that ***only*** individual psychotherapy is needed, and narrow psychology needn't be, either. The crucial point for narrow psychology concerns understanding and explanation, not the number of people involved in therapy. But for some people, such as victims of rape or incest or violence (whose suffering we'll be discussing in Part II), ***group*** therapy can be of tremendous help, by showing them that they're *not* so abnormal, since others have gone through the same thing and are coming out of it;[127] similarly, veterans have "rap groups" to give each other a sense of normalcy, or to face each other's anger down to give them back some semblance of control.[128] Group methods are also a valuable resource for getting elderly people more involved in life, and they are "particularly potent in teaching a person about the feelings behind the social facades of others."[129] And when tense and abnormal family situations contribute to schizophrenic and schizoid conditions, ***family*** therapy is needed to seek a healthier homeostasis in the home.[130] Despite the numbers involved, however, all of these therapies need to employ an individualistic methodology if they are to be successful, since their common goal is to show the individual participants that their attitudes are understood, as a crucial step to changing them.

A second preliminary concern might be that psychological individualism is individualistic in the sense of 'egoistic' or 'selfish'. However, the goal of psychotherapy is to make people independent and in control of their lives, not selfish. Selfishness often contributes to problems – when you live thinking only of yourself, you have to cope with the guilt afterwards, and you deprive yourself of the benefits of interpersonal relations. The treatment for someone who feels increasingly alienated from others is not to drive them further away, but to re-integrate them with society. One of the best ways to get yourself together is to help others; by apparently giving yourself away you can become more of a self. Even Adler (1930, p. 69), the founder of the School of Individual Psychology, finds that it's a useful start to just get patients to *think* about doing something nice for someone, and he testifies,

> It is almost impossible to exaggerate the value of an increase in social feeling. The mind improves, for intelligence is a communal function. The feeling of worth and value is heightened, giving courage and an optimistic view....The individual feels at home in life and feels his existence to be worth while just so far as he is useful to others. (p. 132)

Vietnam vets, for example, find it helps to try to make meaningful contributions to helping other veterans and their families or abandoned children, in order to make reparations for their guilt they feel.[131] Once again, however, there is no objection to individualism as a methodology here, since it is the claim that someone is best understood according to his or her own concepts and

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[127] See Forward (1979, pp. 163-64), or Warner et al. (1980, pp. 135-36) on the merits of group therapy for rape and abuse victims.

[128] See, e.g., Sonnenberg et al. (1985, pp. 118, 183) on vets' "rap" groups.

[129] Edward Murray and Leonard Jacobson, "Cognition and Learning in Traditional and Behavioral Therapy," in Garfield and Bergin (1978, p. 683).

[130] See, e.g., Jackson (1968) on disturbed patterns of communication in schizophrenic families.

[131] See John Russell Smith, "Individual Psychotherapy With Viet Nam Veterans," in Sonnenberg et al. (1985, pp. 160-62).

reasons is perfectly compatible with saying people should try to care more about others, if only to bring fulfillment to themselves.

A third and final preliminary objection concerns the issue of ***prevention***: individual psychology can be faulted for being too much of a band-aid, short-term fix that fails to adequately address the larger social issues that induce suffering or prevent future problems. As Way (1950, p. 163) puts it while discussing Adler's contributions, psychologists shouldn't just be sitting like spiders in their web, waiting for problems to develop – they should try "to set humanity on a better path," by enlightening parents, teachers, school children, and laymen about the sorts of behaviors they should avoid and the problems that can arise. Better parenting is required, for example, because the first four years or so of life, which frame our whole way of thinking about the world (as a hostile or cold place, etc.) and who we are, are the most crucial, so we had better provide children with a good home environment in order to avoid problems later on and raise healthy, autonomous individuals.[132] Children need to be exposed to a variety of viable roles, values, vocations, and options, and they also need to be assured that they're acceptable and worthwhile.[133] In addition, psychologists should become involved in the community by working on the attitudes of the general public which tend to exacerbate certain individuals' problems. E.g., a common attitude regarding rape and incest is, "They asked for it," and this, together with the legal system itself, can contribute greatly to victims' sense of guilt and shame.[134] Our discriminatory attitudes regarding minorities and the poor should be changed, as well, and better still, we should do something about the socio-economic disparities themselves, because as George Albee (1982, p. 1044), for example, points out,

> Poor people, who occupy the lowest rung on the socioeconomic ladder, have the highest rates of crime, alcoholism, delinquency, insanity, and mental retardation. Without an opportunity to move into middle-class respectability out of the crunching grind of poverty, discrimination, unemployment, and dehumanization, their rates will remain high.

While we're at it, psychologists should also do their best to point out how the workaholic Protestant ethic tends to result in impoverished relationships and neglected families. So clearly, there is other work to do – social reform, community psychology, and more. But this isn't inconsistent with the fact that narrow, individual psychotherapy is often needed to help once the damage has been done, and, given this country's conservative sentiments and opposition to social welfare programs, it is unlikely that large-scale changes will occur even *with* the sustained and concerted efforts of intentional and social psychologists, so individual psychology will probably always be needed to help downtrodden people cope with the conditions they find themselves in.

But now let's turn to a larger issue, which can't simply be resolved by distinguishing between senses of "individualism" or conceding the need for community psychology, as well. The problem comes in the form of a dilemma, related to the extent to which individualism and (helpful) clinical psychology hold that the things that are troubling us are "all in the head." If individualism is committed to maintaining the unlikely solipsistic premise that our problems are

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[132] See Way (1950, 66 ff., 204 ff.); and Adler (1930, pp. 76-77, 93-94).

[133] See Glasser (1984, 183 ff.) concerning these suggestions for child-rearing.

[134] See Joan Koerper, "Rape Prevention – Whose Responsibility?" in Warner (1980, esp. pp. 287-95), for suggestions concerning legal reforms, so victims won't be as traumatized by bringing their aggressor to trial as from the original assault.

completely in our heads, it seems to be grossly insensitive, not only to patients,[135] but also to such clinical practices as recognizing and treating such conditions as "shell-shock," whose very classification demonstrates that intentional psychology incorporates external elements into its explanatory practice. But to the extent that it does acknowledge the relevance of external factors, it seems to be admitting that narrow explanations are inadequate. This fourth and far more cogent objection can be distilled into two parts, which will occupy us for the remainder of the Chapter: clinicians would be neglecting part of their job if they didn't take into account the wider environment or social context the subject is responding to, in order to ***diagnose*** the subjects' problems and situate them in an explanatory ***frame***; and, furthermore, individualistic explanations don't seem to give social pressures and traumatizing external ***causes*** their just due. Let's start with the first point, which will take us directly to the difference between the wide frame of an intentional explanation and its narrow content.

On the Frame and Content of Intentional Explanations

In order to do their job of understanding and explaining the way subjects fail to fit in with the world, externalists have argued, psychologist have to *evaluate* their beliefs and determine whether they are appropriate or inappropriate, and that involves situating them in a wider context and thus adopting the wide perspective. Burge (1986, p. 25, his emphasis) for example, submits, "Theories of vision...belief formation...memory, learning, decision-making, categorization, and perhaps even reasoning all attribute states that are subject to practical and semantical evaluation *by reference to standards partly set by a wider environment*." Rather than these areas Burge mentions, however, in what follows I'll continue to concentrate exclusively upon clinical psychology, where the point is equally acute, as we'll see, by considering the problem of wide clinical evaluations and diagnoses and what they portend for individualism. In reply, I shall now be arguing that anti-individualists are right to assert that *part* of the explanatory process involves wide criteria – the part I'm calling the *frame* of an intentional explanation – but that doesn't negate the fact that the actual *content* of the explanation should be narrow.

The **frame** of an intentional explanation of someone's behavior involves the kinds of background items that psychological investigators are required to provide on insurance forms and police reports. To begin with, they give third-person descriptions of the subject's name, age, gender, race, and occupation, to tell us who we're dealing with. Next, they either describe the nature and frequency of the presenting symptoms such as anxiety attacks (in the case of voluntary clients) or else reconstruct the external events which brought them to the attention of the mental health authorities in the first place (in the case of involuntary treatment), in order to inform the audience about what the subjects actually did. Whenever possible, they also include information about what may have happened to the subjects previously (such as child abuse, rape, violent incidents, etc.), as clues to the types of problems they might now be suffering, which ties in with the last

[135] As I have already noted, it is precisely this charge that the disaffected have leveled at Freudians, regarding their doctrine that women are merely fantasizing – they're driven by theory, and their patronizing attitude can exacerbate the hurt and betrayal the victims feel. It is a betrayal of the trust the "patients" place in the therapist when they confide in them, when the analyst doesn't *believe* the secrets they entrust to them. See Masson (1985) who decries such collusion, or Rush (1980), who observes that psychoanalysis took a bad turn when Freud stopped listening to his patients and he turned his gaze inwards, to interpret his own dreams and Oedipal wishes.

(but not least) point, which is that the investigators also ***diagnose*** the nature of the problem, if they can. Since these factors are all external to subjects, I should explain how they complement the narrow program, rather than contradict it.

To start with, the fact that the subjects' public identity *per se* isn't itself a part of the psychological explanation proper should be obvious. Rather, the initial biographical information is needed for other purposes, such as for billing the appropriate agency for the investigator's services, or for future reference for those interested in hiring, firing, or sentencing the subject. A name isn't a psychological phenomena or in a position to be responsible for behavior; some subjects may vehemently deny that they are who we say they are, if they are trying to cling to some other identity, instead (e.g., consider Rokeach's [1964] three 'Christs'); and even those who are all too aware of who they are – try to live up to being a Kennedy, for example – behave as they do because of what they believe is expected of them by those they want to please, not because of the letters that are written on their driver's license.

Similarly, for reasons we've already seen something of in Chapter Two, an externalist, third-person description of a subject's behavior isn't properly part of an intentional explanation, not even as the *explanandum*. The task ***is*** to explain why the behavior ensued, but if we really want to make sense of it, we have to be prepared to reinterpret what the subjects did according to their own lights. To take (another) extreme example, we should not assume at the outset that the subject intended to execute the behavior under the description we may initially assign to it: a deluded subject may attack and kill a milkman making a delivery, as far as the outside world is concerned, but to truly understand what happened, we have to make the connection to the narrow or perceived situation, and see that as far as he was concerned, he was defending himself from a CIA assassin, or some creature from his nightmares.

Accordingly, let's concentrate on the other factors, starting with the potential problem posed by evaluating and diagnosing subjects' problems from a wide point of view, and proceeding to the importance of other people and external situations which may have traumatized the subjects in question.

On Wide Diagnostic Categories

Whether we like it or not,[136] diagnosis ***is*** part of clinicians' task, for several reasons. They have to call their patients' conditions *something* when they offer testimony about subjects' diminished responsibility,[137] after all, and also when they submit their bills to the appropriate agencies.

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[136] And there are many reasons not to like psychiatry's diagnostic practices, which have been forwarded by the "labeling theory" wing of the "anti-psychiatry" movement (occupied by people such as Goffman and Laing), some of which I'll be reviewing briefly in the text.

[137] These types of judgment are required not just within clinical psychology, but for legal purposes, as well. It seems highly likely that we shall continue to distinguish between reasonable and unreasonable actions and deliberate and non-deliberate harm when deciding what to do with malefactors. We must, e.g., decide whether to hold Bernard Goetz liable for the harm he caused to the black adolescent carrying a screwdriver on the subway, based on whether we think it was a reasonable thing to do. That requires that we interpret what the "objective" situation was and decide whether his perception of the situation was warranted, by making a "normal observer" judgment: would the youth represent a menace – or at best an annoyance – to the "normal, reasonable" man? These are crucial judgments to make, because they determine whether we should celebrate the action as heroic or punish it as second-degree murder.

Diagnostic categories are also useful for keeping a record of a patient's own psychiatric history, and for making generalizations about groups of patients with similar problems and the sorts of treatments they may respond to. But since many or most of the diagnostic categories psychiatrists use to characterize people's maladaptive functioning involve factors and perspectives which *are* external to the individual subject being studied, as I'll illustrate momentarily, an anti-individualist such as Burge might be tempted to conclude that clinical psychology isn't individualistic, contrary to my representation of it so far. For reasons I'll now explain, however, that inference isn't sound, because while clinical explanations are not exclusively individualistic affairs, wide diagnoses can not only peacefully co-exist with narrow psychology, but their very employment presupposes the narrow point of view.

To begin with, externalist factors such as reference and truth clearly are invoked in some aspects of clinical practice: witness the very notion of a psychosis, which is defined according to whether the subject 'really knows what's going on.' (The DSM-III, for example, defines "psychotic" as, "A term indicating gross impairment of reality testing...the individual incorrectly evaluates the accuracy of his or her perceptions and thoughts and makes incorrect inferences about external reality, even in the face of contrary evidence."[138]) And the fact that ***social*** norms of appropriateness and rationality are involved in diagnoses is illustrated well by *phobias*, or intense fears that are regarded as *irrational* and "not based on sound judgment,"[139] and even better by *delusions*, where the subjects themselves don't share our evaluation of the irrationality of their attitudes, and their unfounded beliefs aren't widely shared.[140] Some diagnostic categories, moreover, refer explicitly to the subject's unwanted acting-out behavior itself (e.g., kleptomania), and finally, some, such as Post Traumatic Stress Disorder, even refer to the condition's presumed external etiology explicitly.

But do these categories somehow jeopardize narrow psychology? Clearly, the last of them, which adduces external causes of behavior, does pose some threat, so I'll be treating it separately in the next subsection, which deals with the influence of other people. The other categories, however, I shall now argue, aren't problematic at all, for two main reasons: first, most diagnoses aren't explanatory in the least since they just categorize the behavior; and second, even when they do partially explain how subjects came to be in the state they're in, wide diagnoses are only

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[138] This definition of "psychotic" is from the glossary of the DSM-III (1980, p. 367), which hastens to note that it is a matter of degree: “The term psychotic does not apply to minor distortions of reality that involve matters of relative judgment. For example, a depressed person who underestimates his achievements would not be described as psychotic, whereas one who believed he had caused a natural catastrophe would be so described.”

[139] E.g., see Reber (1984, p. 543): “...the fear must be persistent and intense, there must be a compelling need to flee or avoid the phobic object or situation and the fear must be irrational and not based on sound judgement.” Similarly, the DSM-III (1980, p. 225) defines *phobic* disorders or neuroses thus: “The essential feature is persistent and irrational fear of a specific object, activity, or situation that results in a compelling desire to avoid the dreaded object, activity, or situation (the phobic stimulus). The fear is recognized by the individual as excessive or unreasonable in proportion to the actual dangerousness of the object, activity, or situation.”

[140] A delusion, according to the DSM-III (1980, p. 356) itself, is a "false personal belief based on incorrect inferences about external reality and firmly sustained in spite of what almost everyone else believes and in spite of what constitutes incontrovertible and obvious proof or evidence to the contrary." The fact that *social* norms are involved in the judgment that someone is deluded is revealed by the APA itself, which hastens to add that delusions are to be distinguished from what might be called more widely shared dogmas: "The belief is not one ordinarily accepted by other members of the person's culture or subculture (i.e., it is not an article of religious faith)."

part of the story, because they require investigators to take up the narrow point of view in order to understand and explain their ***current*** behavior.

First, the point that wide diagnoses which consist mainly of an abbreviated description of the aberrant or undesirable behavior are of no use in understanding or explaining the underlying disorder is made forcefully here by the phenomenological psychiatrist Buytendijk (1967, pp. 357-58), by way of an analogy with the Kinsey report on male sexuality:

> The *description* of factual behavior in the life-world, for example, sexual behavior, yields no psychological knowledge properly speaking, that is, no *understanding* of human behavior or the human world. The Kinsey Report can be regarded as, at best, a foundation for scientific research. The "facts" which this much-discussed study brings together, are at most as sensational as the announcement that every year in any metropolis so and so many crimes are committed...this knowledge is not scientific-theoretical knowledge, not insight, and, above all, not psychology. The policeman who ferrets out a number of exhibitionists in his area, on the basis of a pragmatically usable "operational notion," no more accomplishes scientific work than the psychiatrist who labels a group of patients "compulsive" or "schizophrenic." In both cases one interprets men on the basis of some characteristics or definite symptoms without insight into their *significance*.

As useful as diagnoses may be in conveniently lumping a number of subjects' conditions under a single term, then, they certainly aren't the end of the matter. Indeed, by themselves, they are apt to do more harm than good, for some of the reasons emphasized by the "labeling" theorists, which are briefly summed up here by Moss (1989, p. 197), while discussing the tensions between "Diagnosis versus Empathy":

> As diagnostician, one is the authority with knowledge and skills, looking down at an object for analysis and diagnosis.
>
> This relationship is often experienced by the patient as a put-down, a further evidence of his or her inferiority and abnormality. In many instances, the patient also internalized this same attitude as a kind of self-judging, self-diagnosis, and self-discounting attitude toward his or her own behavior. ...When abnormal and even unacceptable behaviors emerge, it is not sufficient to revert to the diagnostic frame of mind, label the behavior as *schizophrenic* or *manipulative*, and medicate or otherwise *subdue* the behavior. Rather, even if such intervention is necessary, the therapist is challenged to understand first: How is the patient experiencing this moment, this place, and these persons, such that he or she acts in this fashion? Any intervention will then be informed by an empathic understanding of the person, which guides the behavior into more effective therapeutic channels.

Understanding and treating the condition, then, as opposed to merely labeling it, requires interpreting the subject's experiences, rather than simply categorizing their behavior as being maladaptive in some way. But when we do attempt to explain the disorder by uncovering the significance of the subject's reasons for behaving, we shall find that these wide judgments about the lack of fit between the subject and the world do ***not*** imply that psychological explanations should employ wide content, instead of narrow. Quite the opposite, in fact, because categories such as "grandiose" ideas ("An inflated appraisal of one's worth, power, knowledge, importance, or identity" [DSM-III 1980, p. 359]) only *make sense* if there is an autonomous component in the subject, which constitute his ideas about himself or the world. Such categories involve diagnosticians in a ***comparison*** – between what we 'normals' think, and what the subjects themselves think, i.e., between the public's conception of the world and the subject's notional world. Moreover, to get anywhere in therapy, the investigators have to continue to keep the subjects' perspective in mind, as we've seen, in order to break down their illusions about people

or how they expect them to be (which is why Karen Horney [1950, pp. 347-38] describes the goal of therapy for some patients as a "disillusioning process"), or turn their maladaptive 'closed' system into an 'open' one which takes into account other people's perspectives (as Ronald Fairbairn puts it[141]). To accomplish this, therapists first have to discover what their clients' illusions and misconceptions about themselves and others *are*, and take them into account when they make concrete suggestions for going about changing their behavior, as Moss (1989, p. 196) notes here, since:

> Even simple behavior change, when this is the patient's goal in seeking treatment, is often impeded when the psychotherapist fails to understand the patient's world. The first step toward change that seems so trivial to the therapist, may appear to the patient as a leap into a life-threatening chasm, and repeated goal setting and establishments of rewards and punishments will be ineffectual unless this experience is recognized.

The moral to draw from these considerations about wide diagnoses, then, is that in clinical practice the wide and the narrow points of view work in tandem, since investigators have to adopt the former in order to evaluate and diagnose their clients' attitudes and behavior, and the latter in order to make sense of them, and to help facilitate their clients' recovery and growth. I'll be saying a good deal more about the therapeutic force of empathy in Part II, however, so let's proceed to the other matter: the influence of external events and other people.

On the Contribution of the External World, Social Roles and Other People to Our Behavior

As we've seen, Rogers (1951, pp. 483-84) and other notional world psychologists describe our cognitive life as consisting of an internalized phenomenal field centered around a phenomenal self. But this constant mention of "phenomenal" worlds may raise the suspicion that methodological solipsism is far ***too*** solipsistic, insofar as it brackets out the external world and other people altogether. And with all my emphasis on individualism, it may sound as though I am committed to totally discounting the importance of social roles – but I don't, I'll be acknowledging how they come into play in at least two important ways. So, for the sake of both consistency and the record, I had best explain how individualistic clinical psychology is to accommodate such matters once more, starting with the external world, and moving to the importance of other people and social roles.

Individualism and the External World

To start with, as Kant submitted when he explained the idea of a phenomenal world, and as clinicians such as Piaget have rediscovered since, our knowledge *begins* with experience generated from the external world.[142] In other words, we seem to need input from the outside, not

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[141] Fairbairn, as Padel (1987, p. 272) notes, "described the nature and aims of psychoanalytic treatment as a technique for the analyst's efforts to breach and turn into an open system that closed system which the neurotic patient did his best to maintain in his dealings with the world. Reber (1984, p. 127) defines a *closed* system as, "A system, actual or theoretical, that is bounded off from other systems and operates or is conceptualized as operating without externally imposed additions or changes," while an "open" system "can be adjusted and modified" (p. 491).

[142] See Kant's Introduction to *The Critique of Pure Reason* (1787), B 1: “There can be no doubt that all our knowledge begins with experience. For how should our faculty of knowledge be awakened into action did not objects affecting our senses partly of themselves produce representations, partly arouse the activity of our understanding to compare these

only to get the cognitive ball rolling, but also to keep it going on a sane keel, as the studies on sensory deprivation have revealed. But does this contradict individualism, which restricts its explanations to internal factors? Not at all, for reasons I'll explain.

It's true that some notional world psychologists may be idealists who claim that there is no independent non-intentional reality (such as some guises of Husserl[143]), but they needn't be. Narrow psychologists can perfectly well acknowledge that there is an external world that is instrumental in forming our cognition, since their central claim isn't that we're making everything up when we think about things, rather it's that whatever representations are instrumental in producing an individual's subsequent behavior must be internalized in order to have any effect. Of course, there are real objects in the external world which we literally bump in to, but the extent to which we take them into account when we are planning and executing our actions depends entirely upon the representational structures and intentional objects that are built up within our individual minds, which serve as both a buffer between and a means to obtaining external objects and influences. And narrow attributions don't *deny* the existence of the external objects our intentional states may or may not refer to, it just ***brackets*** that question or "holds it in abeyance,"[144] which means that this methodology is solipsistic only insofar as it doesn't refer *essentially* to (what we assume to be) real external objects when describing our psychological processes, i.e., it avoids appealing to what some philosophers call "Russellian" thoughts, which are definitely about some particular existing object.[145] In other words, narrow intentional psychology holds that the objects of our psychological attitudes or intentional states inhere in those states, which in turn inhere in the subject.

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representations, and, by combining or separating them, work up the raw material of the sensible impressions into that knowledge of objects which is entitled experience?"

[143] On Husserl's "transcendental idealism," see his (1970), or Spiegelberg (1964, p. 112): "In his radical insistence on absolute or "apodictic" certainty as the foundation of all philosophy and science, Husserl subjected the other person and his world to the same kind of "reduction" or bracketing as that to which he had treated all other parts of the "transcendent" or trans-subjective world. Initially, this did not mean more than that the existence of the intentional referents of our acts was to be kept in abeyance. But more and more it came to mean that all the acts in which these acts were constituted in conscious-ness were to be suspended, with the result that eventually these referents appeared as constituted *by* consciousness. In other words, phenomenology became a special kind of idealistic philosophy, a phenomenological or "transcendental" idealism."

[144] E.g., see Valle, King, and Halling (1989, pp. 10-11) who introduce Husserl's views on 'bracketing' and their relation to the clinician's task, as they are understood by phenomenological psychologists:

"As we go about our everyday tasks, ...we think ...that what we experience is a direct reflection of what is "out there." Husserl (1970) referred to this naive belief in the independent existence of what is given in experience as the "*natural attitude*." In the modern world, the natural attitude includes those beliefs adopted from science....

The existential-phenomenological psychologist, however, assumes a different position or vantage point...that Husserl (1962) refers to as the "*transcendental attitude*." ...In order to understand a given phenomenon, one attempts to suspend or put in abeyance one's preconceptions and presuppositions. In phenomenology, this process is called *bracketing*...or *reduction*, as one quite literally reduces the world as it is considered in the natural attitude to a world of pure phenomena or, more poetically, a purely phenomenal realm....

In the reduction, therefore, one does not categorically deny the existence of the phenomenal world – the client did not simply fabricate the events he or she described [such as abandonment] – but rather one puts in abeyance one's belief that the world is independent of each individual person....the existential-phenomenological psychologist views the individual and the world as co-constituting one another and, in this context, we all help to make the story of our lives what it is. The world... is not an external conglomeration of entities any longer...but rather a *world-for-consciousness*."

[145] For more on "Russellian" thoughts, which were christened by Gareth Evans to refer to thoughts about some particular object(s) which wouldn't exist if the object(s) didn't, see, e.g., Noonan (1986), who explains how narrow psychological can get along without them.

It is the recognition of these very internal structures and objects, after all, which differentiates *intentional* psychology from other types of explanatory systems, such as behavioral psychology, which attempts to eschew all such reference to hidden internal processes. Wide psychology of Burge's type, on the other hand, is apparently trying to have it both ways, by admitting the existence of these internal processes, while minimizing their importance to fixing their own content. This is a mistake, however, because even when our basic 'take' on the world is truly faithful to and representative of the external world, it remains something internal to us which guides our behavior, and in the process of assimilating the incoming information into chunks that are useful to our needs, our individual interpretations of what is happening may diverge quite significantly from how the things we may be perceiving "really are in their own true nature," and it is these idiosyncratic interpretations of our "representational world" that determine how we behave, rather than the real thing.

But the real world can't be swept away by a clinical psychologist quite so easily, because as conditions like Post-Traumatic Stress Disorder show all too clearly, it is populated by very real people who can cause us a great deal of distress (as well as joy, of course) and have a considerable impact upon our subsequent behavior, so let's turn to them now.

Individualism and Other People

Even before we get to Putnam's worries about the environmental contributions to meaning (which subjects may be oblivious to), his initial (1975a) exposition of narrow psychology is enough to make one suspicious of the adequacy of a psychology which has to reconstrue states such as jealousy, for example, such that the feelings are connected with internal states or fictitious beings. This seems wrong-headed, because it apparently fails to do justice to the very real and sometimes very hurtful presence of *other people*, who affect us both directly (by beating us, for example[146]) and indirectly, by shaping how we define and what we expect of ourselves. However, acknowledging the existence of other people and how they may have hurt us both physically and psychologically seems to give psychology a different orientation – a wide one. Even Freud, for example, wrote at one point that maybe the motto for psychotherapy should be, "What have they done to you, poor child?" after describing a patient who had been brutally raped and infected with gonorrhea by her own father when she was *two*.[147] Faced with such atrocities, focusing upon internal factors may seem to be a mistake. What can narrow psychology say in reply?

First of all, individualism certainly doesn't deny the existence of other people or their effects on us; clearly, to do so would be absurd. And it certainly isn't committed to denying the existence of rape and incest or their devastating effects, nor does it deny that we can be adversely affected by other sorts of external stimuli – *so long as they register*, or leave some sort of impression on us. Instead, its methodology *is* committed to the idea that traumatic events traumatize us by means of the internal beliefs, desires, and fears with which we perceive the world and in virtue of which

[146] E.g., see the description of the grisly case of Hedda Nussbaum and her psychopathic boyfriend who apparently abused her and murdered her daughter, in the Dec. 12th 1988 *Newsweek*.

[147] The incident and the motto are described in Freud's December 22, 1897 letter to Fleiss, quoted in Masson (1985, p. 117).

we act. The crucial point is, what "they" *have* done is to produce long-term ***internal*** effects in their victims, since to the extent that other people have a significant influence on someone's actions, it is because their values have been internalized, either by being consciously identified with in our ego (if we admire them), or split off as a set of self-censuring introjected attitudes in our superego (if we don't, or if they have hurt us somehow). I shall now explain this point in more detail, and illustrate it with clinical examples.

Other people do affect us deeply, of course, especially our parents, but they only do so insofar as they make an impression on us, an internalized impression which supervenes on our physiology. To see this worked out in detail, we should turn to the so-called "Object Relations" school in psychology, as represented by Fairbairn, Klein, Winnicott, Jacobson, Mahler, Kernberg, Kohut, and others. Their collective approach is introduced here by St. Clair (1986, p. 2):

> Object relations theorists investigate the early formation and differentiation of psychological structures (inner images of the self and and the other, or object) and how these inner structures are manifested in interpersonal situations ...[they] focus on the relationships of early life that leave a lasting impression...residue or remnant within the individual. These residues of past relationships, these inner object relations, shape perceptions of individuals and relationships with other individuals. Individuals interact not only with an actual other but also with an internal other, a psychic representation that might be a distorted version of some actual person.

According to this view, then, other people are represented internally, and to the extent that they influence us, their values and characteristics are incorporated into ourselves, in the psychological processes known as *introjection* and *identification*. The first of these is defined generally by Reber (1984, p. 373) as, "the process by which aspects of the external world are absorbed into or incorporated within the self, the internal representation then taking over the psychological functions of the external objects," and more specifically in psychoanalysis, "the parent figures are the external objects and the *introjects* (as they are called) are the values of the parents." Identification, as we all know, is "A mental operation whereby one attributes to oneself, either consciously or unconsciously, the characteristics of another person or group" (Reber 1984, p. 341). By means of these two processes, we build up the two well-known psychological structures, the ego and the superego, to take over the functions formerly served by our parents or caregivers: to respond to the world in the service of our instinctual drives, and yet temper our behavior so that it is socially acceptable. The ego itself, as St. Clair (1986, p. 28) notes,

> ...can be described as a precipitate of abandoned object choices or abandoned object cathexes. This means that the traces or residues of interpersonal relationships with important people remain and color the individual's identity. Thus, the ego contains within it the history of past object choices or past interpersonal relationships. The traces of past love relationships remain in the child's personality and cause the child to resemble his or her parents.[148]

Thus, according to this view, the main part of someone's personality is actually built up from his or her relationships with others, but only via a process of internalization. Similarly, the super-ego (or "internal saboteur," as Fairbairn 1952 refers to it) is also a repository of others' values as well as an active agency within our persons and personalities. As St Clair (1986, pp. 41, 44) explains

[148] *Cf.* Padel (1987, p. 271) "...according to the *Ego and the Id*, ego as personality has grown by the internalization of renounced love-relationships ('abandoned object-cathexes' was Freud's phrase in English translation), the ego cannot be clearly distinguished from its objects (or 'other persons') with whom it has identified, certainly in health and to some extent in pathology."

with reference to the work of Melanie Kline (I have omitted his references), the superego first arises from the children's perceptions of their parents' or guardians' more critical and fearful tendencies as they are filtered through their own aggressions:

> Introjection builds up an inner world that partly reflects the external world; projections of inner feelings color the infant's perceptions of the external world. In the effort to defend themselves, infants try by phantasy processes to impose their own inner world onto the external world and then reinternalize that world. In essence, the infant is creating his or her own world.
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> ...Children create within themselves unreal and phantastic images of parents who hurt them, who seem to cut, devour, and bite. These dangerous objects become internalized as wild beasts and monsters, and the child dreads being devoured and destroyed...amalgamated with the greed and fear of the infant, [they] become the superego, the introjected object that bites and devours. The superego, of course, does not accurately represent the parents as they actually are, but is constructed out of the phantasy images of the parents that the infant takes into itself, modified and altered by its own feelings and phantasies.... In fact, it is the child's own feelings, cannibalistic and sadistic impulses, that make the early superego so harsh.... The child experiences these incorporated objects or parents in a concrete way, as living figures within who hurt and persecute.

It is these introjects, then, which continue to regulate or even condemn the individual's behavior later in life, as we'll be seeing in more detail in Parts II and III, long past the time we have any meaningful contact with the *real* parental figures, so the impact of others on our behavior is well within the resources of an individualistic Object Relations theory approach.[149]

But what about those cases when it's *not* just the children's imagination that their parents are hurtful or sadistic, and they actually are abused and traumatized: are individualists committed to saying their problems are still all in their heads? In a sense, they are, because after the bruises heal, whatever *lasting* psychological effects there are have been incorporated within the child's personality somehow. As clinicians such as Ferenczi and Fairbairn have observed, abuse victims frequently either internalize their aggressors' own harsh estimations of indictments against them into their superego (after they've been told they deserve what's happened because they've been "bad"), or they more consciously identify with and live up to them in their ego and through their subsequent behavior in the attempt to defend themselves against bad relationships or a hostile and otherwise hopeless environment.[150] In either case, the damaging effects of others are

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[149] In case you still doubt whether object relations theorists *are* individualists, however, see, e.g., Brice (1984, p. 119): "In its precise theoretical usage, the term "object relation" does not describe the meeting between person and other and certainly not the meeting between I and thou. The term is restricted to an internal relationship between self, image of self, and internal image of other, i.e., between self and self. Psychoanalytic object-relations theory...deals only with mental representations of person and world, which is consistent with the natural scientific, energic-instinctual model upon which it is based. Even the most mechanistic theoretician would not suggest that an object cathexis involves a flow of energy from one to another – a flow of energy which would somehow envelop someone. Theoretically, these relationships exist only within the mind, within a closed mental system."

[150] On the phenomenon of "Identification with the Aggressor," see Ferenczi (1932), and for a description of the patterns of behavior of rape and abuse victims, see, e.g., Forward and Buck (1979) or Warner *et al*. (1980); I will be returning to these themes in Part II. As St. Clair (1986, p. 19) explains here with reference to Fairbairn's 1943 work "The Repression and the Return of Bad Objects (With Special Reference to the 'War Neuroses') (reprinted in Fairbairn 1952, esp. pp. 66, 67), "The child defensively internalizes what is bad or frustrating in his or her environment. A child would rather become bad than have bad objects in the environment, and so becomes "bad" by defensively taking on the badness that appears to reside in the objects. The child seeks to make the objects in his or her environment good by purging them of their badness by taking them on and making them part of his or her own psychological structure. The price of outer security is having troubling bad objects within; in other words, the world is good but now the child is "bad." Once the bad object is within the child, he or she has to further defend against the internalized bad object by

reflected by factors within the subjects which can properly be appealed to in intentional explanations. Similarly, when the traumatizing episodes involve natural disasters or acts of violence against individuals other than the subjects themselves, they only develop into stress disorders insofar as some internal psychopathology results, such as recurrent nightmares about the events and an acute sense of guilt for surviving or for not doing enough to save their friends when others may have died.[151] We'll be hearing more about both these sorts of cases in Part II, however, when I discuss how psychotherapists go about treating such conditions, so for the time being I just want to emphasize that to the extent that they *remain* problems, such problems are *sustained* by the internal factors that fall within the province of individualistic psychology.

Thus, individualistic psychology seems to be able to accommodate the influence of other people. It's true that there are some schools of psychology which emphasize social factors and interpersonal relations at the expense of self psychology, such as the Harry Stack Sullivan's Interpersonal Theory, but they are vulnerable to the objection that they neglect intrapersonal psychology, as Silvano Arieti explains in the note.[152] However, since a psychology that reduces the influence of other people to internalized "objects" or relations between factors within the personality may seem to be suspicious on the grounds that it is not only explanatorily inadequate, but also demeaning, I shall now provide clinical illustrations of the point.

Object Relations in Clinical Practice

Although it may seem demeaning to submit that our relationships with and feelings about other people are of an "I-It" character (to use the Existentialist Martin Buber's words), rather than being genuinely "I/Thou," in that we respond to them as if they were two (or fewer) dimensional objects according to our preconceived notions about them, it's not inaccurate. In order to see this point about the existence and importance of introjects more clearly with reference to the original example of jealousy, I shall now argue, we don't have to appeal to the possibility of inhabitants

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repressing any awareness of the object or feelings about it. In religious terms, this might be expressed as, "It is better to be a sinnner in a world ruled by God than to live in a world ruled by the Devil." The sinner may be bad, but there is a security in a world ruled by a good object. In a world ruled by bad objects, there is neither security nor hope."

[151] See Sonnenberg et al. (1985) on some of the problems confronting Viet Nam veterans.

[152] In his "The Present Status of Psychiatric Theory," Arieti (1968, p. 1636) explains,

"More than any other author Sullivan has the merit of having shown that one becomes a person by virtue of relations with other human beings and not by virtue of inborn instinctual drives...a gigantic contribution. However, it is impossible to encompass the whole field of psychology and psychiatry in an exclusively interpersonal framework. This framework deals with what goes on between A and B, but not with what goes on inside A and inside B. Yet every psychological phenomenon starts and ends intrapsychically; every interpersonal phenomenon is coupled with an instrapsychic one...[which] is at least as important... especially in such phenomena as cognition, symbolism, and emotion....

By concentrating on interpersonal relations the Sullivanian school minimizes the importance of the inner self or of the total psyche of man: it focuses on an extremely important, but nevertheless partial, interpretation...by visualizing the self as made of reflected appraisals or other external influences, it overlooks the self's autonomous characteristics.

People influenced by Sullivan have continued his pioneer work within the interpersonal frame of reference. They have opened new areas of psychiatric inquiry by studying the person in the social context in which most psychological phenomena originate, develop, and deviate. However, in what seems to be a deeper vision of the larger context, we must carefully avoid the danger of not respecting the person in his own separateness, individuality, and autonomy.....For instance, ...some authors see schizophrenia exclusively as a social or intrafamilial drama. They do not take into consideration the fact that the drama has to be internalized in specific abnormal ways in order to lead to the psychosis."

of Twin planets or of Evil deceivers who might serve as sources or objects of our affection equally well without our knowing the difference, as is usually done in the philosophical literature: instead, we can see it exhibited in real clinical cases involving extreme manifestations or absences of introjects. We'll start by turning to schizophrenics once again (in whom so many psychological phenomena are either strikingly exaggerated or absent), and then move to hysterical or histrionic personalities, to understand why some people get far *too* jealous, and sometimes not *enough*, because of who they think they're dealing with and what they mean to them.

Schizophrenics have been called that because they are *split*, considered from both within, as the normal psychological processes become fragmented,[153] and without, in that they not only withdraw from other people and their ways of thinking and communicating (as we've already seen), but after a certain point their relationships with them also really don't seem to register, either, as Mendel (1974, p. 124) explains:

> In the course of a nonschizophrenic existence, the human being differentiates himself from his surroundings through a series of sequential relationships with others. Some remnant of each of these relationships remains part of his existence, and all future relationships are built upon it. The event of prior relationships becomes incorporated into his existence as part of his history, his experience, and his anticipation. In a way, part of each experience sticks to the individual's ribs, like a good meal....In the schizophrenic existence there seems to be no remaining lives history at any one moment. When the experience stops, it is as though none of it stuck to the ribs of the schizophrenic existence....Within hours... [there is] nothing left of the...memories, pains, separation anxiety, loss, and remembered pleasure and sadness.

This, then, is one of the reasons for the "blunted" or "inappropriate" affect" schizophrenics are said to have:[154] frequently, other people and their doings *don't* seem to concern them as much as they perhaps should. Thus, sometimes (non-paranoid) schizophrenics *won't* feel jealous in circumstances that would more than provoke the rest of us, because the other people involved, both the love-object and the potential threat, simply don't mean much to them (although the case is just the opposite with paranoids, who are given to jealousy of delusional proportions). Moreover, these two facets of splitting away from others, poor communication and poor internal object relations, may be even more intimately related, because the latter may actually explain the former. According to Cameron (1944) and Sullivan (1944), schizophrenics' communication is impaired *because* of their undersocialization and their inability to take our roles and so tailor their speech so that we can understand them.[155]

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[153] On the etymology of "schizophrenia," which literally means "splitting in the mind," see, e.g. Reber (1985, p. 666), who explains that it "...was chosen by [Eugen Bleuler, who coined the expression] because the disorder seemed to reflect a cleavage or dissociation between the functions of feeling or emotion on the one hand and those of cognition on the other. That is, the "split" here is horizontal and not vertical; the latter dissociation yields *multiple personality*, a decidedly different psychiatric syndrome."

[154] Altered, split, blunted, or inappropriate **affect** or emotional responses were one of Bleuler's "four A's" concerning the fundamental disurbances in schizophrenia (e.g., see White and Watt 1981, p. 470; the others involved associations, autism, and ambivalence); and they are still part of the diagnostic criteria for schizophrenia: see the DSM-III (1980, p. 181 ff.).

[155] See, e.g., White and Watt (1981, pp. 493-94) for a brief account of Sullivan and Cameron's views, or Cameron (1944), who remarks, "*It is our view that disorganized schizophrenics are persons who never have developed very adequate role-taking skills and have, therefore, not been able to establish themselves firmly in their cultural pattern*. In the face of emotional conflicts and disappointments, they find themselves unable to resist a progressive withdrawal from social participation into a fantasy life, into which they can carry their problems for solution or lose them entirely. At first, it

Too few people, then, make any real impact on schizophrenics, and consequently they often don't have much influence upon them or elicit much of a response. That's why psychotherapists can frequently only begin to make progress with them by somehow getting through to them and inside their skins; but rather than getting into all the difficulties of psychotherapy with schizophrenics now (see my [forthcoming], however), let's turn to the flip side of this capacity (or incapacity) to internally register the existence, qualities, and values of others, one which can paradoxically end up at the same place. That is, let's turn to cases of ***hysterical*** personalities, upon whom other people initially make too *much* of an impact, such that they either respond to some people as if they were someone else, or the others are idealized to the extent that eventually the real people can't possibly live up to the imaginary ones, and consequently these subjects, too, lose interest in them.

An hysterical or histrionic personality disorder, as Reber (1984, p. 325) defines it, is

> ...usually characterized by immaturity, self-centeredness, attention-getting, manipulativeness and quite, often, a vague seductiveness. Such persons are overly dramatic, reactive, and intense in their interpersonal relationships and frequently play out classic roles like "princess" or "victim."

These individuals are sometimes apt to become jealous inappropriately, when they overdramatize what others may have done, or overestimate the degree to which they have supposedly committed themselves to him or her. And as R. D. Laing (1969, p. 32) explains here, real people frequently fail to live up to what an hysteric such as ***Madame Bovary*** may expect of them based on their internal phantasies:

> The hysteric may have, paradoxically, intense sexual desire and never achieve complete sexual gratification....the hysteric cannot be entirely gratified by his or her private phantom relationship and is yet unable sufficiently to forego the phantasy relationships to make way for the naked reality of an actual one, for no real relationship can be trusted not to be too disappointing....Hysterics frequently say they have more real feelings in imaginary situations than they can experience in real ones.

Similarly, Brice (1984) describes a case where a woman had a series of relationships with other self-absorbed people that were based more upon her images of them than on any genuine shared understanding or interaction between them, so it was no surprise that none of them went anywhere (see the note[156]). Cases such as these illustrate why it is appropriate to construe our emotional entanglements as involving internal objects, and they take us directly to the

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may be, they merely decline to participate in the field of social behavior. But unless their growing fantasy life is broken into, its techniques will come in time to dominate all their activity and... ultimately replace their underdeveloped and now waning social skills, even in operations in the social field where they cannot possibly succeed. (p. 62)

...The schizophrenic...is speaking in an asocial dialect full of idioms ...[which he] has fallen into...in the course of growing more and more isolated from others....He is no longer able to take your role in the situation, to put himself in your place and then speak more from that vantage point..." (p. 55)

[156] To provide a clinical example of a self-object relation, Brice (1984, p. 112) writes,

"This woman insisted that her current paramour cared about her greatly and was thoughtful and attentive to her, although no evidence substantiated these claims. When her relations with her lover were closely examined, it was found that he related to her almost out of a sense of duty, as the others had dome. If she initiated sex, he would have it; if she invited him to dinner, he would eat it, and so forth. No evidence existed to even hint that he genuinely cared for her as a person. The turning point in therapy came when she courageously risked not phoning him for two weeks in order to see if he would take the initiative to call. When no call came, the patient was "devastated," but this experience constituted her first clear understanding of how she related to people only as she wished them to be."

phenomenon known as ***transference***, which is defined generally as "the passing on, displacing or 'transferring' of an emotion or affective attitude from one person onto another person or object" (Reber 1984, p. 785). As Freud pointed out, transference shows up not only in everyday relationships, but especially in the psychotherapeutic relationship, as Rollo May (1964, pp. 174-75) comments:

> The concept and description of transference was one of Freud's great contributions, both in his own judgment and in that of many of the rest of us. There are vast implications for therapy in the phenomenon that the patient brings into the consulting room his previous or present relationships with father, mother, lover, child, and proceeds to perceive us as those creatures and build his world with us in the same way....one's ancestors, like Hamlet's father, are always coming on to the edge of the stage with various ghostly challenges and imprecations.

As we'll see in more detail in Part II, an integral part of psychotherapy is thus to analyze the ways clients transfer various sorts of attributes to their therapists, often inappropriately. As might be expected, the problem can emerge acutely in the case of borderline personalities [who have some of the characteristics of both hysterics and schizophrenics], as St. Clair explains in the note.[157]

Thus, an internalized object relations theory can not only accommodate the influence that "significant others" have had on us, but it can also explain why our responses to other people are often distorted; and when they *are* seriously distorted, as the object relations theorist Kernberg notes, "Part of the therapist's task is to call attention to the discrepancy between the patient's view of the therapist as an archaic phantasy object and the therapist as a real object."[158] Of course, it may be objected that by concentrating on the fantasies of abnormal cases, I have distorted the possibility for more authentic relationships, but ironically the truth seems to be rather that genuine "I-Thou" relationships are *idealizations*, which are to be strived for but never truly realized (unless we were able to develop telepathic powers), whereas the introjects we act upon are genuinely efficacious. This is because we can't actually experience the other person's experiences or know them *directly*, as seems to be required;[159] instead, we can just interact with them on the basis of increasingly faithful representations that are more attuned to their true character, thereby enjoying closer and closer encounters, as it were, and that requires introjects, which are in the province of individualistic psychology.

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[157] As St. Clair (1986, pp. 139-140) explains with reference to the work of Otto Kernberg (see next note), "...the borderline patient tends to rapidly develop a transference that often seems chaotic and is predominantly negative.... One aspect...is *projective identification*, a primitive form of projection where the patient externalizes aggressive self-image and object image and continue to relate to the object in a an effort to control the object that is now feared because of this projection...[it] is typically manifested as an intense distrust and fear of the therapist, who is experienced as attacking the patient. The patient may try to control the therapist in a sadistic or overpowering way. The patient may be aware of his or her own hostility but more likely feels that he or she is just responding to the aggression of the therapist....What is projected onto the therapist is a primitive, sadistic parent image, and the patient experiences him or herself as a frightened, attacked child. Moments later, this may shift so that the patient might experience himself as the stern, sadistic parent and the therapist as the guilty, frightened child."

[158] Otto Kernberg, *Borderline Conditions and Pathological Narcissism* (New York: Jason Aranson, 1975, p. 82), quoted in St. Clair (1986, p. 140).

[159] E.g., see Brice (1984, p. 110): "Within the I-Thou relation, subject and object evaporate; a "we" emerges in which the partner authentically meets the other and himself...the relationship is mutual, and is direct."

Individualism and Social Roles

Social-minded externalists, however, might concede for the sake of argument that the influence of other people can partially be accommodated as internalized intentional objects, but they can reach into their other sleeve for an additional set of arguments concerning the importance of ***social roles***. Since social roles do seem to be vitally important to the concerns of intentional psychology, these objections seem to warrant a reply before I conclude my case in defense of narrow psychology as against wide, and go on to contrast it to two *too* narrow approaches. I shall begin by setting out the sociological objections, and then provide an individualist's response to them.

Humans are social animals, it's long been argued, and we don't act in isolation. Rather, we play certain social roles, and social roles are social constructs which don't begin and end with the individual. Role-playing isn't simply a matter of thinking up a part and reciting some lines, because others are involved, as well: both an audience and other players (although other players such as co-workers watch our performances, too, of course), plus whatever elements in society produced and scripted those roles in the first place. Since these roles define or even dictate the behavior that is expected of us and form our very 'selves' and identities to such a large degree, and since we seem to *occupy* them far more than we *initiate* or *invent* them, it seems to follow that the individuals who implement them are social constructs, as well, and to that extent their actions seem to be products of their cultures. Thus, strictly individualistic explanations cannot give a complete account of our reasons for behaving.

In reply, I shall begin by granting what truth there is in this claim that a self is a social construct rather than something which supervenes on a subject, before going on to explain why such sociological insights should properly be viewed as complementing individualistic explanations, rather than fatally embarrassing them. We do play a lot of roles, of course; as William James, for example, comments, a man practically has

> ...as many different social selves as there are distinct *groups* of persons about whose opinion he cares. He generally shows a different side of himself to each of these different groups. Many a youth who is demure enough before his parents and teachers, swears and swaggers like a pirate among his "tough" young friends. We do not show ourselves to our children as to our club companions, to our customers as to the laborers we employ, to our own masters and employers as to our intimate friends.[160]

And granted, it is right to say that we don't make these roles up all on our own – we are *told* and sometimes *showed* how to be a good spouse, parent, etc. And granted, too, that if we are to pull off a certain role – e.g., to be regarded as a *bona fide* blues guitarist (as the Republican Lee Atwater aspires to be) – then significant others (such as B.B. King) have to accept us in that role (although they may be doing so for reasons of their own having little to do with the actual performance), so I agree that *successfully* presented selves or characters depend upon the collaboration of others, who decide to support us in our roles instead of undermining them or denying their authenticity or legitimacy.

[160] The excerpt from *The Philosophy of William James* (New York: Modern Library, pp. 128-29) is quoted by Goffman (1973, pp. 48-49); Goffman (1973, pp. 252-53) also presents an objection to individualistic accounts such as the one given in the text, based upon the observation that successfully presented selves require the cooperation of others.

But since it may seem I've already conceded too much, from my client's point of view, let me now move on to individualism's defense. In brief, the key point to recognize here is that these external influences are the *distal* cause of our behavior, not the proximate cause. In other words, they are the *input* to which we respond, and so while they may be properly acknowledged in the *frame* of an intentional explanation of our subsequent behavior as much as we want, they only belong to its *content* insofar as they are actually influential in producing it, and they only influence our subsequent behavior insofar as we both i) *care* enough about what others think of us to modify our behavior accordingly (as James noted above); and ii) we have been able to successfully *internalize* the values and characteristics that others expect us to exhibit. Anything else lies beyond the goal of a strictly intentional psychological explanation, and belongs to the domain of a different and complementary area of inquiry. Allow me to elaborate.

When these social roles *are* internalized and we *do* care to act on them, intentional explanations can and should refer to them in order to make sense of our behavior (e.g., "She did X because she was trying to be a good mother, and that's what she thought a good mother should do"), and so long as we don't impute to subjects a more sophisticated *or* impoverished conception of the role they were trying to fill than they truly had at the time of acting, there need be no argument between sociologists and narrow psychologists about such cases.

When we *haven't* internalized enough of these roles, however, in some circumstances we may get the vague or even acute sense that we *should* have, because we feel (or are made to feel) awkward and out of our element, because we don't quite know *how* to act. In such instances, we will often *do* very little on our own, preferring to mimic others, but narrow psychology can readily explain this in terms of our fear of embarrassing ourselves. And in the more abnormal cases, when the disparities between the performances that are expected of subjects and ones they are disposed to conceive of and act out for themselves are much greater, such undersocialized subjects often *don't* behave as expected; but here again, this is only to be expected on the narrow account, because these subjects have either internalized very little of these roles or they disregard them quite a lot, so there's no conflict. As we'll see in Part II, one of the goals of psychotherapy for such clients is for the therapist to teach them how to behave in the company of others (partly by his or her own example), but since teaching is a process of getting subjects to internalize new information or assimilate new ways of behaving, there doesn't seem to be anything in clinical practice surrounding the importance of social roles that contradicts individualism, either.

People don't generally *create* the roles they go on to perform *de novo*, however (except for extremely creative individuals, of course), but then again, narrow psychology isn't committed to saying that they are. The crucial point from its point of view is that the script has to be internalized if the subject is to act out his or her own part. To the extent that these *are* actions (as opposed to mindless rituals or reflex actions) and so the proper targets of intentional explanations, the type of character the actors are trying to portray and the sense of their action is somehow represented within themselves. This is illustrated in studies such as Goffman's (1973), which shows how we must sometimes *perform* for others and become certain types of *characters* for them, even if we personally find them a little strange or ridiculous.[161] In other words (Jung's),

[161] Goffman's (1973) study provides a dramatic illustration of how we *perform* for others by consciously adopting certain characteristics that are expected of us. Since this is particularly true in work settings where employees serve the public and have to adopt a certain demeanor, and it stands out more when we encounter and try to mix with someone from

frequently we adopt a certain ***persona*** when dealing with others, which means that we intentionally behave a certain way and project a certain kind of character for their behalf, and as before, intentional acts have inherent intentional objects.[162] Consequently, it's a mistake to think that these selves we try to be for others are *just* a dramatic effect created by the scenes we find ourselves in, because even though the roles were mostly originally conceived by others and then handed down to us, it's all too true that too many people are trying desperately to be accepted in certain kinds of identities, and that we *do* try to live our lives according to cherished roles.

That brings us to the next point, which is that ***succesful*** role-playing depends on the collaboration of others, who must take us seriously in our chosen role. In this case, however, we are explicitly importing judgments of truth and reference, and so we're going beyond the boundaries of what is required of a strictly intentional inquiry, for the sorts of reasons we've seen before. That is, people don't act *because* their beliefs are true – at best, we just act because we *think* we know what's going on, which is sufficient to impel us into action; *cf.* Fodor's (1981, p. 243) discussion surrounding the advice to "buy low/sell high" in this context, which doesn't help much when we've been trying to do just that. So although it is true that the responses of others (whether they applaud, ignore, or even deride someone's performance) can influence whether subjects will dare to attempt some behavior *again* and help to reinforce or extinguish their characters, it is nevertheless the case that the success that their actions may be met with upon completion isn't in a position to determine why they are actually acting at the time. Hence, whatever generalizations concerning successful roles *qua* successful roles there may be, however interesting they may be from the point of view of characterizing a society, they simply aren't part of intentional psychology's mandate concerning the behavior of any particular individual – except insofar as he or she is aware of them, of course, as when someone deliberately emulates the behavior of a current movie star in order to try to curry favor with members of the opposite sex of a certain persuasion. So although it's hard to be another John Wayne if others keep treating you like Pee Wee Herman, that doesn't mean that you won't keep on *trying* to be just that.

But what about the sociological claim that our very selves or identities are determined by these various and fluctuating social roles? E.g., Brice (1984, p. 110) argues that the theoretical implications of Martin Buber's Existential Relational Theory, which emphasizes the "I-Thou" relationship that exists *in between* persons, are profound, because it

> ...implies that the question, "Who am I?" may be answered only by asking another question," "With whom?" It implies that the most complete development of the self is the development of the self in relation to another person or persons.

However, this isn't inconsistent with individualism, which ***doesn't*** say that subjects have a fixed or one-dimensional character, or that they should be studied in complete isolation, or that we

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another culture, Goffman's study concentrated on a hotel on Shetland Island that catered to tourists. Going behind the scenes, Goffman describes how the egalitarian and down-to-Earth Islanders who worked in the hotel had to put on certain airs they thought were ludicrous in order to satisfy their more priggish clientele.

[162] "Persona" is defined by Reber (1984, p. 352) thus: “From the Latin, meaning *person*. In classical Roman theater, it was a mask which the actor wore expressing the role played. By extension of this notion, Jung used the term in his early formulations to refer to the role that a person takes on by virtue of the pressures of society. It is meant to refer to the role that society expects one to play in life and not necessarily the one played at a deep psychological level. The persona is public, the face presented to others.”

shouldn't take into account whatever stimuli they're subjected to. Again, what it ***does*** say is just that subjects' consequent purposive behavior should ultimately be explained with reference to their internal states and purposes alone. So although I do admit that to a large measure our parents and/or significant others made us who we are today, and also that who we continue to be from moment to moment depends upon who's around at the moment, that's perfectly consistent with maintaining that our reasons for acting at any particular time are in our heads. For example, although it *is* relevant to some teenage boy's behaving aggressively toward someone that his peers and girlfriend (versus his grandparents, say) were present at the time, but that's because they initiate a certain number of internal processes, such as his thinking, "They expect me to be strong and to stand up for myself, so I better take care of this guy;" the fact that it *is* the internal factors that we should be appealing to in the final analysis, however, is revealed in this instance by the fact that if he knew the girl a little better (but now he never will), he'd know that's the *last* way she expects someone worthy of her affections to behave.

And finally, one last example should suffice to show how the sociological and psychological perspectives can be complementary, rather than antagonistic, and that what gets emphasized, the internal or the external factors, is very much a function of the pragmatics of the situation. If you want to know why Smith suddenly got up and scolded his friends and asked them all to leave, the psychological answer, which emphasizes *his* reasons, is that he decided to try to act responsibly instead of continuing to set a bad example, but the sociologist who is more concerned with why the individual happened to choose *this* particular moment to hold forth on the virtues of sobriety will be more interested in noting the arrival of his wife and children, who tend to remind us of such things.

An extreme existential individualist may wish that there weren't any such thing as social roles which confine the identities of the people who are raised by them and prevent them from being more true to themselves, but the truth seems to be, "If they didn't exist, we'd have to invent them." Children in particular are hungry for these roles to help shape and develop their own self-identity, even if they have to go searching for them in fairy tales or on television; e.g., Shapiro (1990, p. 58) reports,

> By the age of 4 or 5,...children start to embrace gender stereotypes with a determination that makes liberal-minded parents groan in despair. No matter how careful they may have been to correct the disparities in [stories read at home], ...their children will delight in the traditional male/female distinctions preserved everywhere else: on television, in books, at day care and preschool, in the park and with friends. "One of the things that is very helpful to children is to learn what their identity is," says Kyle Pruett, a psychiatrist at the Yale Child Study Center. "There are rules about being feminine and there are rules about being masculine. You can argue until the cows come home about whether those are good or bad societal influences, but when you look at the children, they love to know the differences. It solidifies who they are."

Similarly, although I don't mean to endorse the types of sexist roles that children are being exposed to or that they adopt, I can't emphasize enough that people ***do*** adopt these roles, which are crucial to structuring their sense of self and of how to behave in relation to others (*cf.* Sandler and Rosenblatt [1962] or Erikson [1956]) on the importance of identity formation and change), and that this is a process of internalization or introjection. Thus, to the extent that they are influential in our behavior, social roles are quite compatible with an individualistic framework.

Conclusion to Part I: Why Important Portions of Intentional Psychology Are and Should Be Narrow

In sum, I have been arguing that the explanations of individual intentional psychology are and should be individualistic, i.e., that they should not violate the principle of methodological solipsism in the way the externalist philosophers such as Putnam and Burge suggested on the basis of sociolinguistic considerations. To do so, I have submitted, would be to obstruct their dual purpose, which is to render plausible causal explanations which enable us to understand an individual's own reasons for behaving. Wide attributions, I've argued, have the very real potential to seriously misunderstand what individual subjects really mean by what they say and do; they obscure important commonalities between subjects who happen to be embedded in different environmental or linguistic contexts; and they are patently inadequate when it comes to unconventional subjects. Moreover, their explanations are quite suspect on causal grounds. Thus, I've argued that intentional psychologists frequently have to be prepared to put the default meanings that we conventionally assign to the things people say by the boards, and use their empathic and interpretive skills instead, if they are to get at what we're really thinking and feeling in order to account for our behavior, particularly our maladaptive behavior. For clinicians working with actual subjects to do otherwise would be to court disaster – a point I'll be returning to in Part II while considering the approach of psychologists who would make no attempt at all to interpret the content of subjects' mental lives, much less an insufficiently individualistic one.

In pursuing the argument, I have also attempted to elucidate clinical practice in such a way as to accommodate some of the elements non-individualists emphasize. In the *frame* of an intentional explanation, for instance, a clinical psychologist adverts to wide factors such as the behaviors the subject engages in and the traumatic situations he had been through, and he or she also evaluates the subject's thinking and emotions in non-narrow terms (as unrealistic, inappropriate, lacking objective reference, and so on), and labels them such things as a "paranoid schizophrenic." But to fill in the picture inside the frame – to give *content* to the explanation – individual psychologists need to go narrow, by relaying the content of the subjects' delusions or misconceptions or whatever from their point of view, in order to make sense of the ensuing behavior. E.g., a veteran reenacting a traumatic episode may believe that he was shooting at a Viet Cong operative, even though in reality his victim was a harmless postman or a VC operative, and we won't be able to understand his action until we appreciate that fact.

Similarly, I also showed how narrow psychology can accommodate the influence of other people and social roles. Of course, other people, particularly our parents, are vitally important in shaping and maintaining our identity (as "A man or a mouse," e.g.), but I'm not claiming that we *would* have got this way on our own in some strong sense, or that we're making everything up when we act. Rather, the individualist's compound point is that other people and external objects only affect us psychologically insofar as they *do* make an impression on us, and these impressions supervene on our physiology. In a sense, then, other people aren't different in principle from other things in the world that we are aware of, in that they are represented internally, but they could, for all we know, be figments of our imaginations, or inputs cooked up by an Evil Deceiver or computer. Thus, even though it's probably true that our internal images and object relations are intimately connected to real persons, it's these internal representations which are important to our conduct, and they often don't match the genuine article very well, as evidenced by the

transference reactions of hysterical and borderline personalities, and the impoverished relations of schizophrenics. The bottom line is, intentional behavior is mediated through the individual subject's own private world, and everything he (or she) thinks and desires that is relevant to accounting for his behavior is thought inside his head, or not at all, so intentional explanations had best continue to restrict themselves to such internal factors.

Chapter 4:
Notional World Psychology vs. STM

Contents

These next two chapters constituting Part II will examine the clash between the content-based paradigm of notional world psychology and its recent challenger, the Syntactic Theory of the Mind (or STM), which has been advocated by the philosopher Stephen Stich. In order to rebut Stich's challenges to "the integrity and scientific utility of the commonsense notions of meaning and intentional content" and his allegation that intentional locutions "are not the sort of locutions we should welcome in serious scientific discourse,"[163] I will examine the utility of knowing what's on (or ***in***, actually) people's minds, as contrasted to the poor results that are likely to result if psychologists – particularly *clinical* psychologists – were to follow Stich's advice to ignore the content of people's attitudes about themselves and the world, and concentrate instead on more abstract characterizations of their cognition.

My rationale for focusing on the clinical domain once again is straight-forward. Despite the fact that philosophers of mind have almost completely ignored it, the matter of therapeutic application is central to the debate about the importance of intentional content in psychology for the following reason. An extremely important factor in evaluating competing paradigms is to gauge their problem-solving abilities. In this case, a critical part of psychology's problem domain is to help psychologically disturbed people. Thus, any theory that is to phase out or replace intentional psychology must do at least as much as the latter does in the guise of "notional world" clinical psychology, because if it can't, and we continue to need content-based psychology for therapeutic purposes, then the charge that it is unsuitable or superfluous is simply mistaken.

The basic argument of these Chapters is actually quite simple: (1) we do need some sort of therapy for our psychological problems; (2) psychotherapy is the most appropriate mode of treatment for these problems, especially since it has some success, while existing alternatives are ineffectual or worse; (3) psychotherapy employs content, projective understanding, and the constructs of folk psychology such as belief and memory; therefore, (4) folk psychology and content *are* suited to the needs of psychology, and (unless something drastic happens) probably always will be.

In Chapter Five, I will respond to some of Stich's substantive criticisms of the intentional approach. This Chapter, however, is organized as follows. The first Section will review the clinical literature on the nature and extent of some of the major life disturbances which affect millions of us in order to establish the problem domain and develop at least a *prima facie* case for why psychotherapy is the most appropriate mode of treatment, at least for neuroses. Section Two will explain what notional world psychotherapy is, and how it deals with such problems. The third major Section will examine the theoretical and practical limitations of the challenging paradigm, the Syntactic Theory of the Mind, and argue that it lacks the resources to adequately treat our psychological problems.

[163] Stich, "Narrow Content Meets Fat Syntax' (forthcoming, p. 3); *cf.* Stich (1982, p. 204), which speaks of the "darker suspicions...that the notion of a contentful belief or memory, borrowed from folk psychology, may be singularly unsuited to the purposes of scientific psychology."

The Problem of Human Neuroses

As long as social problems such as neglect, discrimination, rape, abuse, violence and war exist, I shall be arguing, we're going to have miserable people in need of help, help that content-based psychotherapy is best able to provide. As the first step to establishing this, this first Section will review the nature and extent of some of the major psychological problems which can be precipitated by these external causes.

The Psychological Effects of War, Violent Crime, and Other Traumas

The huge growth in the field of clinical psychology after the second World War, as well as its change in orientation from testing children's intelligence and personalities to providing psychotherapy for adults, were both largely due to the recognition that *war* creates severe psychological disturbances.[164] War, in short, is *traumatic*; it seriously affects not only those in combat roles, but also noncombatants such as medical personnel, and the local populace, as well, as we'll see.

"Battle fatigue," "shell-shock," "war neurosis," or "Post-Traumatic Stress Disorder" (PTSD) as it is now called – whatever the name, it is a concomitant of war, especially wars that involve *psychological* warfare, such as particularly gruesome means of killing *designed* to frighten soldiers into submission. Veterans (particularly Vietnam veterans) were exposed to constant and very present danger, and many saw their comrades and women and children blown to bits in front of them by grenades and mines (see Sonnenberg *et al.* [1985, pp. 5, 47; subsequent page references in this paragraph are to this edition]). Combat survivors blame themselves, either for merely surviving (pp. 5, 47, 171), or for some of the atrocities they may have committed or witnessed (such as killing children, torturing or mutilating POW's, or raping villagers: p. 110). Many vets are plagued by nightmares (p. 5), flashbacks (pp. 104, 130) and altered, fugue-like states[165] (pp. 10, 306), and more are given to substance abuse (p. 5) and have an inability to form relationships or keep jobs. Their typical psychological problems are projection, paranoia, and anti-social behavior (p. 184);[166] e.g., they sleep with their guns, or compulsively talk about their friend's mutilation even on a casual date.[167] Some returning vets develop abnormal, maladaptive behaviors that get them in trouble: "flashback behavior;" "action junkie" behavior (seeking dangerous situations); and criminal "revenge," "punishment," and "outlaw" behavior.[168]

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[164] See Bernstein and Nietzel (1987, e.g. p. 28): "The war left over 40,000 men in VA neuropsychiatric hospitals, and there were not enough clinical psychologists and psychiatrists to deal adequately with these patients."

[165] According to Reber (1985, p. 289), "Fugue" = df. "From the Latin for *flight*, a psychiatric disability the defining feature of which is a sudden and unexpected leaving of home with the person assuming a new identity elsewhere. During the fugue there is no recollection of the earlier life and after recovery amnesia for events during it. Often called *psychogenic fugue* to distinguish it from other syndromes that have similar symptoms but are caused by known organic dysfunctions.]

[166] The (Sonnenberg 1985, p. 184) reference is to John Russell Smith, "Rap Groups and Group Therapy for VietNam Veterans."

[167] See John Russell Smith, "Individual Psychotherapy with VietNam Veterans," in Sonnenberg (1985, p. 145).

[168] See Bruce Pentland and James Dwyer, "Incarcerated VietNam Veterans," in Sonnenberg (1985, esp. 408-10). Concerning their numbers, Gelman (1988, p. 63) reports, "According to a report released by the House Committee on

People who served in non-combative roles such as medical personnel, chaplains, and those on graves registration duty are also traumatized by their wartime experiences, as Lipkin *et al.* report, and since many of them obtained noncombat duties because of fear of injury or death or opposition to war, "These veterans "may have a particularly complex problem with survivor guilt."[169] Those on the receiving end of war develop problems, too – those who were shelled, or were prisoners of war and concentration camps. Prisoners of war often developed dissociated personalities to help them cope; it is easier to take if it all seems unreal.[170]

In addition to war, other types of catastrophe can cause PTSD, including accidents, disasters, massacres, violent assaults, hijackings, and rapes, as Rosenhan and Seligman (1984, p. 221) note; PTSD itself is defined in terms of its three characteristic symptoms:

> (1) the person becomes *numb* to the world; (2) the person *relives* the trauma over and over again in memory and in dreams; and (3) the person experiences symptoms of *anxiety*. The anxiety symptoms include excessive arousal, over-alertness, trouble concentrating, memory impairment, and phobic avoidance of situations that are reminders of the trauma. In addition, the individual may be wracked with guilt about surviving the catastrophe when others did not.[171]

Stress disorder victims develop many undesirable symptoms, including depression, crying spells, irritability, sleep disturbances (being awakened while screaming from nightmares), stomach pains, tension headaches, phobias, extreme jumpiness or startle responses, and unsatisfactory sexual relations (Rosenhan and Seligman 1984, pp. 224-25). Clearly, they are in need of some sort of therapy to help them resume normal interpersonal relationships and overcome their depression and anxieties.

The Devastation of Incest and Child Abuse

Despite himself,[172] Freud was certainly right about one thing: key events in our sexual history can have a devastating impact on our psyche and ruin our life if we do not seek help – especially coercive sexual experiences.

Like victims of rape, sexually abused children also sometimes develop Post-Traumatic Stress Disorder; as a result, they sometimes compulsively mutilate themselves.[173] Later in life, many women who were abused as children develop borderline personality disorders – they become "people whose relationships, emotions, and sense of self are all unstable and who often become

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Veterans Affairs in 1979, more than 400,000 vets were in prison, on probation or parole or awaiting trial. (No later estimates are available.)"

[169] John Lipkin, Arthur Blank, and Raymond Scurfield, "Forensic Assessment of Post-Traumatic Stress Disorder in VietNam Veterans," in Sonnenberg (1985, p. 429).

[170] See, e.g., Laing (1969, pp. 82-83) on problems such as dissociation.

[171] Rosenhan and Seligman (1984, p. 221); *cf.* the DSM-III's (1980, pp. 236-38) definition of PTSD.

[172] As I explain in more detail in Appendix A (based on Masson [1985]), early in his career (in 1896), Freud argued that childhood "seductions" (although "rape" is often a more apt term) are a major cause of neuroses such as hysteria, but to his discredit he soon abandoned that hypothesis in favor of the view that reports of incestuous experience are mainly based on fantasies.

[173] Bessel van der Kolk of the Massachusettes Mental Health Center trauma center (cited in Holzman 1988, p. 50); *cf.* Rob Lusk and Jill Waterman, "Effects of Abuse on Young Children," in MacFarlane, Waterman, *et al.* (1986, p. 106).

inappropriately angry or injure themselves...[or who] 'space out' or feel as if they are outside of their own bodies at times."[174] Male victims tend to become misogynists (Forward 1979, p. 75), and reportedly up to 75% of rapists were abused as children (according to one New Jersey study cited by Forward [1979, p. 23]). However, according to Forward's (1979, pp. 9, 20) estimate, 90% of child sex abuse victims are female.

Sexual molestation makes the person feel different, dirty, and disgraced (Forward, 1988). Incest victims harbor tremendous guilt, feel the burn of the treachery, and think they're the lowest of the low (Forward 1979, p. 19). There are many factors contributing to their sense of guilt. Children can't conceive of adults – especially their parents or uncles – as being bad, so when they are abused and they start to feel bad, they think that it's because *they've* been bad (Forward, 1988). They also blame themselves for what they take to be their complicity in the affair, for in many cases they participated in the shameful activity more or less willingly or enjoyed it, and they come to think that they should have resisted more. Another major guilt factor hampering incest victims involves the process of introjection we heard about in Chapter Three. Today it is sometimes called "the Patty Hearst syndrome," but Sandor Ferenczi (1932, pp. 297-98), one of the first contemporary therapists to notice it, describes it here as "identification with the aggressor":

> The children feel physically and morally helpless, their personality is still too insufficiently consolidated for them to be able to protest even if only in thought. The overwhelming power and authority of the adults renders them silent; often they are deprived of their senses. *Yet that very fear, when it reaches its zenith, forces them automatically to surrender to the will of the aggressor, to anticipate each of his wishes and to submit to them; forgetting themselves entirely, to identify totally with the aggressor*.
>
> ...the most important transformation in the emotional life of the child, which his identification with the adult partner, an identification based on fear, calls forth, *is the introjection of the guilt feeling of the adult*, which gives hitherto innocent play the appearance of a punishable act.
>
> When the child recovers after such an attack, he feels extremely confused, in fact already split, innocent and guilty at the same time; indeed his confidence in the testimony of his own senses has been destroyed. In addition to this, the behavior of the adult parent has become harsh, for he is now more than ever plagued and angered by remorse, which makes the child feel even deeper guilt and shame.

These feelings of guilt and shame that are assimilated by abused children never really leave, and they spend much of the rest of their life feeling degraded and useless. Moreover, they carry around their terrible secret and are deprived of a normal childhood, and they bottle up the anger. The first people that they have relations with exploit and betray them; after this, it is very difficult to have fulfilling relations, to trust anyone with their love again. As adults they often block out their painful childhood memories entirely, but they're still depressed and unhappy, and they haven't been able to forgive themselves for crimes they've now forgotten – the crime of trusting deviant adults (Forward, 1988). Sometimes, their identification with their aggressor results in a splitting of the personality, with one part still identifying with the pre-traumatized innocent child.[175]

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[174] This characterization of borderline patients is provided by Kohn (1987, pp. 56-57), reporting on the studies of John Briere.

[175] E.g., both Ferenczi (1932, pp. 300-301) and Rosenhan and Seligman (1984, p. 264) report that the original splitting into multiple or split personalities is usually associated with some traumatic event.

Sexually abused girls often become very depressed women with poor self-images who go through a string of broken marriages, and either abuse their own kids or are fanatically overprotective of them (Forward, 1988). Two patterns of behavior typically result (sometimes alternating in the same individual): being unable to bear having sexual relations, or being utterly promiscuous (Forward [1988], Kohn [1987, p. 57]). They are often suicidal; prone to migraines, substance abuse, prostitution, broken marriages, or violence; and sometimes they emotionally abuse men to "get even."[176]

Clinicians have also found that *adoption* sometimes has analogous effects. When children are wrenched from their homes and know that they are adopted, their feelings of self-worth can be seriously impaired, producing disturbing consequences.[177] Furthermore, abuse in the form of physical abuse and emotional neglect and manipulation on the part of the parents can produce lasting untoward consequences.[178] So hungry are we for their affection and so afraid (sometimes quite justly so) of their disapproval, our lives can be controlled by our parents' use of violence, threats, and subtler means, as Breggin (1980), writing on "Techniques of Parental Oppression," explains in the note.[179]

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[176] This list of behavioral symptoms is discussed in Forward (1979), pp. 25, 68 & 26, 4 & 24, and 102-03, respectively. They are confirmed by other clinicians: e.g., Judith Beck, Persida Drakula, and Carl Gorham, "The Role of Professionals in School or Community Settings," in Warner (1980, p. 173). The relationship between sexuality and violence established by such experiences is explained here by Masson (1985, p. 149) as he elaborates on the ground breaking paper by Ferenczi (1932): "...the parent who denies what he has done, or denies its harmful effects, often becomes physically abusive toward the child (projecting the wickedness onto the child). A seduction is generally followed by violence, suggesting to the child a connection between sexuality and violence, with disastrous effects on the child's ability to love later in life. As a defense the child sinks into a dream or trance state in which it is easier to misperceive the quality of the aggression. The child's need to deny altogether what has happened severely loosens her hold on reality."

[177] Concerning the problems adopted children sometimes develop, see, e.g., Rosenhan and Seligman (1984, pp. 261-66) discuss Jenny, a multiple "who created Julie, a gentle personality, to cope with her parents' putting her up for adoption at age eight." On the other extreme, R. D. Laing (1961, 72 ff.) had a client who was troublesome as a child (after reasoning that since he was adopted, he must be wicked, so he'll *be* wicked) who later began to beat his wife and drink heavily when his son reached the age he was when his mother left. *Cf.* Gordon (1975, pp. 31-32), quoting a 13 year-old who was just starting to rebel against her parents and values: "They told me so often how bad I am and how I can't be trusted that I just do more things they don't like. If they already think I'm bad and stupid, I might as well go ahead and do all these things anyway." Gordon notes that "Children often become what their parents tell them they are," (p. 32) and that constant put-downs cause low self-esteem and can handicap the child for life (p. 114). *Cf.* Freud, in *The Ego and The Id* (**SE** XIX, p. 520): "In many criminals, especially youthful ones, it is possible to detect a very powerful sense of guilt which existed before the crime, and is therefore not its result but its motive. It is as if it was a relief to be able to fasten this unconscious sense of guilt on to something real and immediate."

[178] Harlow's experiments, in which monkeys are reared with wire and terry-cloth "mothers" instead of the real thing, provide ample confirmation for those who require experimental evidence for the claim that we need affection; they are recounted in McNeil and Rubin (1977, pp. 363-65), e.g., and cited to make this very point by Schoonover in Bassuk *et al.* (1983, p. 20). Interestingly, in his interview with Evans (1976, p. 38), Harlow himself reveals that he and his colleague Suomi discovered that the most effective way of overcoming the depression induced in the isolated monkeys through neglect is to provide them with a younger monkey's therapeutic relationship, because "...an emotionally destroyed animal is not afraid of an infant half its age [and]...the therapeutic infant provides a basis for modeling behavior.... The isolate animal soon adapted and felt at ease with the normal animal, and then it followed and learned, primarily by modeling and sharing various activities of play, and then, lo and behold, it was recovering."

[179] Here's Peter Breggin (1980, pp. 134-35) on the effects of parental oppression:

"In my experience as a therapist, punishments in the form of severe beatings are far more common than usually suspected, even in the higher socioeconomic classes. More often, however, the threat of physical force is more heavily veiled. The child must deal with a clenched fist, a twitching hand...But physical assaults and threats are by no means the

Child battering and neglect take quite a toll, as Ney (1987, p. 391) reports:

> It is apparent that without treatment abused children are likely to become abusing parents. During adolescence, suicide is three to six times more likely in abused children than in comparison subjects. Alcoholics who have been abused as children have more legal difficulties, more domestic violence, more serious suicidal attempts, and higher situational anxiety. Maltreatment is commonly found in the histories of children who are delinquent, runaway, violent criminals, prostitutes, and those with chronic intellectual or neurological disabilities.

Emotional neglect might very well be connected with sociopathology, as the movies and some defense attorneys would have us believe.[180]

As we are about to see, psychotherapy is just the thing to help abuse victims, by providing them with a 'safe' supportive relationship that will not hurt them, and to help them to expiate their feelings of guilt and shame and to build up their self-esteem. But not only do the abused parties need some sort of psychological or psychiatric treatment to help them deal with their feelings of aggression and degradation, but their abusive parents do, as well, especially considering that as many as half of the battered children who are returned to their parents by authorities may subsequently die from new injuries (Fontana 1985, p. 1821). The families of incest victims are characterized by loneliness and hostility before the abuse (Forward 1979, p. 4), and the cycle tends to perpetuate itself when they punish themselves by marrying cruel men (Forward 1979, p. 22). The abusing fathers usually were themselves abused as children in some way, and often also use alcohol to help them cope with their feeling of inadequacy (Forward 1979, pp. 32-33); this is also true of the parents who beat their children (Fontana 1985, pp. 1820-21). This vicious cycle must be broken. It can be, as we'll see, with the judicious use of psychotherapy.

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main or most important methods for implementing parental rule. Maternal suffering is probably the most common technique of all. The mother displays her anguish on a daily basis to her child, blaming it on the child and using it to insist upon unerring obedience. The suffering may be displayed directly, in facial grimaces and a moanful tone of voice, or through complaints about headaches and backaches. The child may be told directly how he or she has been a burden, starting with the awful pregnancy and painful birth.

Some of the most self-hating individuals I have met in therapy have been the victims of chronically depressed mothers. No longer aware that they feel to blame for mother's misery, they go through life feeling that they are to blame for every atrocity in the universe. They spend their lives feeling sorry for other people, or feeling guilty over personal "crimes" they cannot identify because of their hidden origins in childhood.

Withdrawal of parental love rivals parental suffering as a method of control and is, at times, inseparable from it. Sometimes the parent takes this to the extreme of threatening to abandon the child....Parents also control their children by systematically terrorizing them about the condition of life outside the family. A young girl is taught to fear all strangers, to distrust her friends, and, in extremes, to scurry back and forth from school in fear of rapists and bullies....All this is done to the child partly in the interests of delaying any attempts to reach for love or for help beyond the family."

[180] As Fontana (1985, p. 1821) indicates, he and Menninger certainly think that violence and emotional neglect are related: "Karl Menninger believed that...the criminal is a child who has survived maltreatment physically and who has suffered at the hands of unrestrained, aggressive, and psychotic adults. It would appear that the probable tendency of abused children is to become tomorrow's murderers and perpetrators of other crimes of violence, if they survive. It has been theorized that children so treated have an unusual degree of hostility toward parents and toward the world in general....In a study of six male adult prisoners convicted of first-degree murder, all were of middle-class families and of good social standing. Four case histories showed continuous, remorseless brutality suffered during childhood at the hands of one parent in the face of compliant acquiescence by the other parent."

The Effects of Community Attitudes and Expectations

According to the phenomenological, existential, or notional world model I am defending, many psychological disturbances are the results of the alienation of our selves from the world, from those around us, and even from ourselves. Not only are we alienated from our often meaningless work, as Marx noted, but there are also other processes and pressures trying to make us what we don't want or know how to be. We're *supposed* to play roles we might find uncomfortable or too demanding, roles that society and our families impose upon us, roles that write our life drama for us or script our part. Consequently, we worry about whether we're doing our part and valiantly try to live up to what our characters are supposed to be, but often we fail, and our failures have psychological costs.

Two of the main societal sources of stress and alienation are families, and the disparity we encounter between our culturally-induced expectations and ideology and the harsh realities of life. In a forthcoming work, I will examine how social roles and expectations can be exacerbating influences in "borderline" personalities and schizoid conditions (when a displaced self *just* plays the roles prescribed for him without identifying with them) and in some forms of schizophrenia (when people slip into madness to cope with family tensions), but in this subsection, I will draw on the testimony of some social and clinical psychologists who note the role of community attitudes in producing depression and neuroses (when someone thinks, "I'm not good enough, I'm not fulfilling my role"). Here's where the notional world model's resources really come into "play": we are expected to play certain roles, but they not fit us, or we them, and we have troubles adapting. To an important extent, the world – the social world – ***is*** a stage in that we all have our parts to play, parts we find grating and degrading or unfulfillable and we fault ourselves for our failures in performance.

Some people are subjected to strict religious and moral scruples in childhood, and develop "superego" problems later. For example, some are taught that sex is dirty and bad, and is only for procreation; this contributed to the problems of "A Husband and Wife Who Have Not Had Intercourse During Thirteen Years of Marriage."[181] Similarly, some people still feel terrible guilt and shame because they have masturbated. Such states are known as "superego anxiety," as Nemiah notes, sometimes resulting in psychotic depressions when people "are convinced that they are the greatest sinners of all times and that all the ills of the world can be laid at their door," and they can induce neurotic symptoms such as obsessive-compulsive disorders.[182]

Fortunately, the depression- and guilt-inducing influence of religion in the West is waning,[183] but despite that fact, there has been an increase rather than a decrease in the overall rate of

[181] See therapist John Gullo's account of this neurotic couple, in Ellis (1971).

[182] John Nemiah, "Anxiety States (Anxiety Neuroses)," in Kaplan and Sadock (1985, p. 886).

[183] E.g., see Heinz Lehmann, "Affective Disorders: Clinical Features," in Kaplan and Sadock (1985, p. 809):
"Systematic research into the changes in depressive symptomology during the last century has determined that in the Western Judeo-Christian sphere of civilization there has been a notable decrease of guilt feelings, particularly in relation to transcendental or religious issues. It is estimated that guilt feelings, which used to be characteristic of endogenous depression in 70 to 75 percent of all cases, now occur in only 30 to 40 percent of cases. Instead of moral feelings, there has been a clear increase in feelings of personal inadequacy."

depression in this country.[184] This shows that depression is not *just* induced by religious guilt – we have plenty of other reasons to be depressed these days. Some of these reasons are culturally induced beliefs and roles which contribute to a variety of neuroses, especially in women. As the therapist Janet Wolfe[185] remarks, women have traditionally been over-represented in the psychotherapy population, and they are most frequently afflicted with psychological disorders that are linked to their powerlessness, such as feelings of inadequacy, chronic low self-esteem, guilt, passivity, depression, anxiety, agoraphobia, obesity, and anorexia; as Wolfe explains,

> These symptoms are a natural by-product of women's being steeped from childhood in the idea that their worth and happiness should derive from living for and through others....Sex roles and sex-role stereotypes are correlated with weight problems....In a culture where a women's self-worth is seen as depending on her body image, the media feature skinny prepubescent girls as sexy, an ideal difficult to attain by adult women, for whom it is biologically realistic to have more body fat than do men or teenage girls.
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> ...Many working women must deal with prejudices from society and themselves: for example, that they are damaging their children permanently by working and that if they decide to work, they must be superwomen – hold down a job, attend to the physical and emotional needs of their children, and do all of these things perfectly – to the point of physical and psychological exhaustion....The option of remaining childless is also fraught with difficulties. There is still a stigma attached to the woman without children; she tends to be labeled deviant, infantile, or unwilling to accept the "feminine role."

Not only are women traditionally viewed as second-class citizens, but the poor and ethnic minorities are, as well, and they also suffer from the effects of culturally-induced low self-esteem. In opposition to theories about the genetic defectiveness of impoverished ethnic groups, Albee (1982, p. 1048) points out that "historically each ethnic group occupying the lowest rung of the socioeconomic ladder had the highest rate of severe emotional disturbance and of mental retardation, but as they moved into the middle class their rates declined," and asks us rhetorically, "What happened to all those bad genes?"[186]

On the same theme, Leo Srole[187] writes about the acute social pressures in America:

> The keystone of the democratic creed is the doctrine that, whatever their native endowments, all men are intrinsically of equal worth before God, the law, and their fellows. With considerable intensity, children tend to incorporate this canon as a bulwark in their still fragile image of themselves. As we have seen, however, in many areas of his experience the lower-class child encounters the contempt, implicit but palpable, in the nonverbal behavior of others who think of him in the symbolism of such

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[184] As Elkin *et al.* (1985, p. 307) report, "...the President's Commission on Mental Health estimates that about 20% of this nation's citizens will have an affective disorder in their lifetime. Preliminary results from a community survey suggests a *current* prevalence rate of 6.8% for major and minor depressions combined."

[185] Janet L. Wolfe, "Women," in Ellis and Bernard (1985), pp. 101-102, 110, 115.

[186] Here Albee (1982, p. 1048) expands on the issue of mental or genetic deficiency in immigrants:
"In America the Irish in 1860, the Scandinavians in 1880, the Eastern European Jews in 1900, and the Southern Italians in 1910, each in succession, provided the lion's share of the insane and the retarded. But as each of these groups worked their way out of poverty and into the middle class, their rates of psychopathology declined. In 1920 the Russian Jews and Southern Italians were regarded by many in psychiatry and psychology as constitutionally defective. They did poorly on intelligence tests – 40% of the New York City Italian school children were called "feeble minded" – and they accounted for a large proportion of first admissions to state hospitals. Today the children and grandchildren of the Russian Jews and Southern Italians are indistinguishable in terms of incidence of retardation and psychopathology from the other members of the middle class. What happened to all those bad genes?"'

[187] Leo Srole, "Socioeconomic Status: Measurement in a Gold-Coast and Slum Area," in Srole *et al.* (1978, pp. 270, 271, 272).

> words as rubbish, scum, dregs, riffraff, and trash. These devastating judgments inevitably force their way into his own self-evaluation process. Thus, he is caught between grossly contradictory, mutually exclusive images of himself, torn by a conflict implanted through the agents of society that profess equality and practices invidious discrimination.
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> ...The "poor" boy has a large chance of becoming an unskilled worker, the "rich" boy a corporation executive. By all economic criteria, with support from all the culture media, the latter is a success, the former decidedly less than that. But under the logic of equal opportunity, the difference in the terminus is presumed to reflect differences in character and abilities; *q.e.d*., the laborer is inherently inferior to those in higher economic echelons.

Moreover, even if the unfortunate subject does not reason so himself, he is made to feel inferior by others, and very early on, because of his class or station in life.[188] On the basis of such considerations, Srole predicted that as an adult, the underprivileged child would "be more defenseless against the crises of life and therefore more susceptible to mental morbidity," and that is precisely what the Manhattan Study found.[189]

Falling short of the American dream, many feel like failures and get depressed, or they drop out of society and take to the streets. The less passive ones have other means of dealing with the disparity between culturally induced goals and the reality of their own achievements and prospects: they take to crime and violence.[190] To compensate for their perceived failures, some people even assume the identity of someone great or famous – a process called "fusion."[191]

There are, of course, other cultural myths, stereotypes, and expectations that cause distress for those individuals who do not or cannot conform, but before we examine how psychotherapists and their potential syntactic rivals attempt to relieve such distress, let's take stock of the

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[188] Here again is Srole (1978, p. 261) on the cultural assaults upon the esteem of the lower classes:
"In many human societies, both simple and complex, the typical family is saturated with awareness of its relative "position," "standing," "station," or "status" in the communal scheme of social rank. There are few places where this is more evident as historical fact than on the American scene. ...The child of the slum, to concretize the urban version of low status, tends to find in his [overcrowded] home few responses to his need to feel that he is valued or respected....In a study of school children Neugarten [B.L. Neugarten, "Social Class and Friendship among Children," *American Journal of Sociology* 51 (1946): 305-313.] reports that "social class differences in friendships and reputation are well established by age eleven years." Lower-class children, this investigation revealed, were regarded with indifference or disfavor by schoolmates of higher status, and even more strikingly, they regarded themselves unfavorably. Moreover, they enjoyed no surcease even when they escaped to the movies, comic books, and television. In Hollywood films, "whether by omission or commission, there is an implicit but clear disparagement of anything that suggests 'dirty work' or anyone who labors. Such deprecation pervades all the popular culture media, assailing the worker (and his children) and tending to weaken his ego-image...." [S. Bellin and F. Reissman, Jr., "Education, Culture, and the Anarchic Worker," *Journal of Social Issues* 5 (Winter 1949): 24-32.] ...This picture reveals a life-setting for the slum-level child heavily weighted with impoverishing burdens and deprivations of body, mind, and spirit, to an extent well beyond the more nurturing environment of the middle-class child and far beyond that of the "cushioned" upper-class child.

[189] Srole (*op. cit*. p. 273). In a survey of 2,060 randomly selected Midtown Manhattan dwellings whose results are recorded in "Socioeconomic Strata: Their Mental Health Make-Up" (in Srole *et al.* [1978 p. 314]) Srole and Thomas Langer found, "Among the several [Socio-Economic Strata]-origin groups no significant differences appear in the frequency of schizophrenic signs, anxiety-tension symptoms, or excessive intake behaviors. In all pathognomic dimensions covered, however, there is an *inverse* correlation with parental SES. These dimensions included disturbances in intellectual, affective, somatic, characterological, and interpersonal functioning.

[190] See Robert Merton on "anomie," in Merton (1957, esp. pp. 380-90).

[191] Examples of fusion are phony Elvises (see Rosenhan and Seligman 1984, p. 121) or Christs (see Rokeach 1964), and Mark Chapman, who killed the real John Lennon to protect his borrowed identity.

magnitude of the mental health problem, in order to underscore the extreme urgency of this question of the therapeutic application of psychological paradigms.

Assessing Our Mental Health Needs

Advocates of clinical psychology and psychotherapy are sometimes met with a wishful thinking reaction: "There shouldn't be any therapy, because we shouldn't need it!" Many "normal" people who are very dubious and disparaging of psychotherapy deny that psychological problems are really problems ("They're just faking and whining,") or they have the somewhat self-righteous opinion that no one should need to bring his problems to someone else (everyone should be stalwart, or have "stiff upper lips"). But we must face the facts: many of us *do* need some kind of help. Bad form or not, our lives are plagued with problems; they do bother us, and we must do something about them.

Judging from the heyday of psychoanalysis in faddish California in the 1950's and 60's, however, it might seem as though "psychological disturbances" are really just "diseases of the rich;" i.e., they are not real problems, but merely hypochondria and other such feminine foolishness. There is some truth to this allegation that psychotherapists in private practice have mostly been tending to the troubles of the rich. This isn't surprising, considering that the seriously emotionally disturbed have difficulty holding down a job to be able to afford to pay for a therapist's services, or for the decreasing number of health insurance plans that cover them. However, it would be unconscionable to suggest that no one is truly in need of help for psychological problems, for the grim reality is that ***millions*** of us have real problems that need help.

The Seriously Disturbed

Life is strife-ridden, and as long as we continue to neglect and abuse each other and there are wars and acts of violence, we will be troubled. We're not *all* affected deeply by adverse circumstances, of course, but as we shall see, something like one in five of us are 'thin-skinned' enough to let the woes of the world inside. Moreover, some of us are would be troubled even in Utopian circumstances. So let's do some reckoning on just how urgent the need for qualified therapists is.

Given the range of our problems, probably *everyone* can benefit from psychotherapy or counseling.[192] But here Albee (1982, p. 1043) reports on the ***official*** estimate of the extent of the mental health problem:

> The President's Commission on Mental Health (1978), the reports on the administrator of the Alcohol, Drug Abuse, and Mental Health Administration...and other careful studies concur in estimating that 15% of the population – 32 to 34 million Americans – constitute the "hard core" of the emotionally disturbed. These are persons with depression, alcoholic addiction, incapacitating neurotic anxiety, organic brain conditions associated with old age, and the several functional psychoses.

While the Presidency for whom the report Albee cites was prepared was not the one that counts ketchup as a vegetable [i.e., Reagan] the estimation of what constitutes "serious" disturbance

[192] Call this, "The Communi(ty psychologi)st Manifesto."

may still have been conservative, so let's do some reckoning of our own, and add up the groups of sufferers we know about.

(1). First, let's just take the victims of disasters and aggressive acts: these number in the millions. Let's break this down

– Estimates on the total number of ***incest*** victims range between ten and forty million Americans.[193] Not *all* incest victims develop long-term psychological problems, but probably at least one-quarter to a half of them do.[194]

– Rape victims are a primary constituency – by some estimates, that's one out of every four, or 25 million American women in total![195] If the figures on incest are any indication, at least a quarter of them need therapy.

– Regarding ***child abuse*** in general, Fontana (1985, p. 1816) reports: "According to official estimates from Washington, a million children are being maltreated by their parents each year, as many as 200,000 sexually abused, and probably 200,000 to 300,000 psychologically abused."

– As we all *now* know, ***war veterans*** also suffer from trauma, and many of them need help: about half a million.[196]

Recall also that victims of car-accidents (or plane crashes) and other such violent events also develop PTSD,[197] as do those subjected to man-made disasters such as Beaupol or Chernobyl.[198]

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[193] E.g., Forward (1979, pp. 2-3), estimates there are currently ten million American incest victims; she's somewhat liberal in defining "relative" to include those molesters *perceived* as relatives, but her figures are probably conservative. Jill Waterman and Rob Lusk (in MacFarlane, Waterman, *et al.* [1986, p. 5) report that even on the basis of incomplete (because under-reported) data compiled by the American Humane Society's Clearinghouse, "60,000 to 100,000 children are sexually abused annually in the United States; with this incidence, it would appear that 10 - 14% of American families are affected by child abuse each year." Kohn (1987, pp. 54-56) reports forty million Americans have been victimized. Rush (1980, pp. 4-5), based on a Kinsey study, reports: "approximately twenty-five million women in the United States will experience sex with a male adult before age thirteen."

[194] Kohn (1987, p. 57) reports that at least one in four incest victims are likely to develop serious psychological problems later in life, citing Chris Bagley.

[195] See Forward (1979, p. 3). Charles Nelson, "Victims of Rape: Who Are They?" (in Warner [1980, p. 10) reports that a 1972 Census Bureau survey of women over twelve "showed that approximately one women in six would be subjected to an attempted rape in her lifetime...one in 24 will be the victim of a completed rape." A recent police movie ("Cobra") reported that 250 rapes are committed each *day* in America. The July 16, 1990 ***Newsweek*** reports, "Every hour 16 women confront rapists; a woman is raped every six minutes."

[196] According to a Research Triangle Institute five-year study headed by Richard Kulka, 60 to 75% of the surviving 3.14 million Viet Nam veterans are free from psychiatric symptoms, but 15%, or 470,000, suffer from PTSD (reported in Gelman 1988, p. 62), and 4.5% have bouts of depression, 5% have anxiety, and their 14% incidence of chronic alcohol abuse is higher than the 10% national average (reported in Holzman 1988, p. 50). Then there are Korean War and World War-II vets to consider, some of whom have suffered silently for decades, probably *because* people think ill of psychotherapy and think it's "unmanly." This is one of the attitudes we have to change, for everyone's good.

[197] Lawrence Kolb, quoted in Holzman (1988, p. 50).

[198] In "Disasters, Natural & Otherwise" (in *Psychology Today,* April, 1988, 57-60), Andrew Baum, a professor of medical psychology who researched people who lived near Three Mile Island, reports that the psychological effects are worse

– I shudder to think how many millions of victims or near-victims of violent crime there are that have to cope with their trauma and feelings of vulnerability. Onlookers at school-yard shootings, suicides, etc., also need early counseling to ward off the effects of the shock and stress, to try to minimize the pervasive anxiety and fearfulness that can follow.

– And of course there will be natural disasters such as earthquakes to cope with as well.

(2). In addition to these problems brought on by such violent stimuli, there are other serious categories of mental disturbance as well: the so-called mental illnesses.

We know from the DSM-III (1980, p. 186) and other sources[199] that the lifetime incidence of schizophrenia is about one percent, which translates into two or three million Americans. As I shall argue in a forthcoming work (or see Karon and VandenBos 1981), they, too, can benefit from psychotherapy, and they sure need some kind of help.

Moreover, ten to twenty percent of us will have an affective disorder such as depression in our lifetime.[200] Concerning unipolar depression, the DSM-III notes,

> Studies in Europe and in the United States indicate that in the adult population, approximately 18% to 23% of the females and 8% to 11% of the males have at some time had a major depressive episode. It is estimated that 6% of the females and 3% of the males have at some time had a major depressive episode sufficiently severe to require hospitalization.[201]

Depression is a serious matter, since it often results in suicide, as Rosenhan and Seligman (1984, pp. 349, 351) point out:

> Suicide is the most disastrous consequence of depression, bipolar or unipolar. Depression is the precursor of a vast majority of suicides....Suicide is the second most frequent cause of death among college students....The estimate of 25,000 suicidal deaths per year in the United States is highly conservative, and the real number is probably between 50,000 and 100,000.

As we shall see in more detail in Chapter Seven, suicide is a direct consequence of the negative attitudes which constitute depression, and we must take these thoughts very seriously, for, "Of every ten persons who have killed themselves, eight gave definite warnings of their intentions" (Rosenhan and Seligman 1984, p. 350).

In addition to the most serious disorders, there are a number of other cases of human suffering or lack of development which need to be addressed, which I shall call the "mildly" disturbed.

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with disasters due to human engineering. One explanation for this is that simmering resentment makes us feel worse when we know we have been victimized by greedy, incompetent, or vicious people and not just by bad luck.

[199] E.g., R.E. Kendell's article on Schizophrenia in Gregory (1987, p. 697).

[200] On the incidence of affective disorders, see Schoonover (1983, p. 80); Seligman (1988), or Elkin *et al.* (1985).

[201] DSM-III (1980, p. 217); which also notes, "It is estimated that from 0.4% to 1.2% of the adult population have had Bipolar Disorder." However, since psychotherapists nearly universally admit that they cannot help with mania, I will not be discussing bipolar depression in this work.

The Mildly Disturbed

Although they may not suffer as greatly as PTSD victims, the pervasive evils of society adversely affect many who cannot shut them out unless they retreat into a world of their own: those who suffer from "schizo-affective disorders," including the so-called schizoid personalities such as Laura in *The Glass Menagerie*.

In addition to these shrinking flowers not engaged in life, there are hosts of other less than severely emotional disturbed people: those with "chips on their shoulder;" the insecure and the neurotic; those recovering from disappointments or trying to come to terms with the loss of loved ones; and those afflicted by phobias, obsessions, and compulsions.

Furthermore, as the result of our emotional conflicts and other stresses in our lives, many of us develop psychosomatic ailments such as ulcers or hypertension that can respond well to psychotherapy.[202]

Counseling is also advisable for those close to rape victims, who cannot supply the needed emotional support if they have difficulty resolving the issue in their own minds.[203]

Marriage counseling is also needed even in the absence of crises, to help people get along with themselves and each other. And Lord knows how much hurtful neglect there has been on the part of "significant others," that must be compensated for.

Psychotherapy and counseling have other important applications (at least as far as those who use it are concerned): in *sports* and other activities (it helps people concentrate and put aside what's bothering them); for helping people cope with serious *illnesses*, and helping them to adapt after having major *surgery*; in ridding people of *addictions*; and in helping *refugees* and immigrants adapt to new ways.

Sadly, there are also tens of millions of Americans living below the poverty line whose lives are abusive and violent, and many of them have to be convinced by counselors and social workers that they shouldn't be ashamed of accepting aid to give their children adequate nourishment.[204]

Moreover, consider work and unemployment. As Marx noted, a lot of work is meaningless and degrading, and this impairs people's well-being and self worth. But even worse than having a job

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[202] For example, McNeil and Rubin (1977, p. 303) report: "According to the National Health Survey of the National Center of Health Statistics, peptic ulcers are one of the leading chronic conditions leading to disability. Stomach ulcers afflict 1 out of every 20 people at some point in their life, and each year stomach ulcers cause more than 10,000 deaths in the United States." I will say more about psychosomatic ailments in the next chapter when I argue that far from being able to replace it, medicine needs to use psychotherapy.

[203] "Current research reflects that 50 to 80 percent of raped women lose their husbands or boyfriends following a rape attack...[and clinical experience indicates that an assault on a child can activate the dissolution of a marriage and/or can severely strain a stable relationship" (Warner 1980, p. 213).

[204] The 1988 Census report says 13.5% of the American population lives below the poverty line, which is about $5,800 per year per individual, or about $11,000 for a family of four. (Reported on the CBS news, Sept. 2, 1988.) That's over 30 million very poor people – in America.

is *not* having one, which can make someone unhealthy.[205] Without the safety valve of competent and sympathetic therapists available to alleviate the unemployed's distress, we will suffer increased unrest, strife, and violence in times of recession or depression.

Another thing to take into account is our changing (i.e., deteriorating) family structures. The incidence of divorces and single parent families is drastically increasing, and we probably haven't begun to feel the full effects of this yet.[206]

Another grim statistic heard on news lately is that of this nation's two or three *million* homeless people, 500,000 to 700,000 are children. If America ever were to become a "kinder, gentler nation," and some of these people were brought back into society, after their physical and educational needs were met they would probably still also need therapy to help them try to lead a "normal" life and to help heal the psychic wounds they have suffered at the hands of we normals who have so cruelly neglected and abused them.

In sum, then, the mental health issue is a BIG problem. It would be wrong for society to let people's problems fester and not to offer to help them with their messed up lives, and imprudent too, given some people's potential for violence and the fact that people may become more productive citizens if treated. So we have to do *something* with troubled people – give them psychotherapy, preferably, as I have been arguing. But as you can see, there are millions of troubled people, and not nearly that many therapists, so we need to train more, not call for the demise or marginalization of the profession.

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[205] Drawing on a statistical study of M. H. Brenner ("Personal Stability and Economic Security," Social Policy', vol. 8, 1977, pp. 2-4.), Albee (1982, pp. 1046-47) writes,

"[Economic slumps that throw large numbers of people out of work are followed by increases in the incidence of alcoholism, mental disorders, infant death, and a wide range of other physical diseases....Brenner was able to show significant correlations between periodic economic recessions and increases in the number of admissions to mental hospitals and clinics. Those most susceptible to the stress of economic disaster appeared to be married men between ages 30 and 65 who were reasonably well-educated and earning good salaries. Because sudden unemployment involved both economic stress and damaging effects on self-esteem, these were the people most affected."

More distressing still is when the economic slumps are <u>not</u> merely temporary. Consider the rising unrest in Britain – the 'senseless' soccer riots. With bleak prospects and nothing to live for, the youth become disaffected, with increasing bottled-up anger, frustration, shame, and low self-esteem. America will be facing a similar situation in due course, as more and more nations become industrialized and throw us out of work, and it already has problems in the Appalachians, ex-steel towns, and other areas. Unless our economic system is extensively revised (by work-sharing, etc.) we are going to experience an increased need for therapists' services as our international fortunes decline.

[206] E.g., concerning the rising trend of affluent male single parent TV shows in his "Midseason Review," (*Rolling Stone*, 545, Feb. 9, 1989, p. 143) Jay Martel writes, "Although the Census Bureau does report that there are around 7,252,000 homes headed by single parents, 33 percent of those parents are black, and only 13 percent of them are men. in the new-season universe, 0 percent are black, 75 percent are men and 12.5 percent are gunslingers."

The Therapeutic Rationale of Freud and Rogers

Although the therapeutic goals are slightly different for individual therapists, they boil down to trying to get clients to feel better about themselves and live better, i.e. to improve their mental health. But what is mental health? We may disagree, of course, on what all of its elements are, but *some* of its prerequisites are tolerable self-esteem; a basic acceptance of even the negative aspects of oneself; and some flexibility in interpersonal relations.[207] As we've seen, however, each of these can be stunted or impaired by adverse circumstances or "dysfunctional families,"[208] and until they can be developed or restored, our mental health will suffer. When the problem is a profound ambivalence in the person's attitudes about him- or herself produced by their upbringing, the therapist's role is to get subjects to come to terms with whatever is troubling them by *devaluing* some of the values they have been subjecting themselves to as being too "tyrannical" (see Horney 1950, Ellis 1971).

Starting from this general conception, let's see how Freud and Rogers articulate their individual conceptions of the goals of psychotherapy. Before I proceed, however, perhaps I should allay both the suspicion that I am being overly selective in my choices, as well as the more widespread suspicion that since there are apparently hundred of brands of psychotherapy,[209] probably none of them are sound. In reality, there are only a few main camps – Freudian or Psychodynamic; Rogerian or Existential, Experiential, Phenomenological, or Humanist; and Cognitive/Behavioral therapies, as represented by Albert Ellis. In the general overview that follows, I will be exploring the contributions of each of these major figures and schools, because they are regarded as the most influential by practicing therapists.[210] As we'll see, they stress insight and interpretation, "real" therapeutic relationships, and maladaptive cognitions, respectively. However, as a number of commentators have observed,[211] they differ more in emphasis than in substance. To achieve consistently good results, therapists of *any* school must provide good relationships with their clients, identify the cognitions underlying their maladaptive behavior, and attempt to correct them; the fact that their commonalities are greater than their differences would explain why they have largely the same measure of success.[212] Why, then, are there are so many specific types of therapy? Because many charismatic and insightful people write their own books and name their own therapies, such as Fritz Perls' "Gestalt Therapy," the uniqueness of which, it is said,

> ...does not lie in a theory of personality or of the neurosis; nor for that matter does it lie in theory at all. It is essentially a non-verbal creation, an approach to people in the therapeutic situation which has

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[207] These criteria are forwarded by Swonger and Constantine (1983, p. 12).

[208] I gleaned the term "dysfunctional family" from an Oprah Winfrey show. Oprah was abused herself, and is to be commended, for she often has victims and clinicians such as Susan Forward on her show to bring this important issue out into the open and to encourage people to seek help.

[209] By some reckonings, there are between 200 and 450 varieties of psychotherapy; e.g., see Karasu (1986, p. 325).

[210] According to a recent survey of 800 clinical and counseling psychologists asking them to rank the psychotherapists whom they considered to be the most influential today, the top three, in descending order, were Rogers, Ellis, and Freud. The study was by D. Smith, "Trends in Counseling and Psychotherapy" (*Psychologist* 37: 802 ff., 1982.), and was reported in Ellis (1985, p. 4) and Warga (1988 p. 56).

[211] E.g., as Sloane (1969, p. 500) concludes in his comparison of these schools, "It would seem that there are more similarities than dissimilarities among various psychotherapeutic approaches."

[212] Jerome Frank makes this suggestion in "An Overview of Psychotherapy," in Usdin (1975, p. 14); this general equality of effectiveness between the various schools is cited in many places, e.g. Bergin and Garfield (1978, pp. 139-89), or Gregory (1987, p. 662). I will be discussing psychotherapy's effectiveness in the next chapter.

> developed out of understanding, experience, and intuition, and continues to be transmitted nonverbally.[213]

As this example indicates, the different flavors of psychotherapy are more geared towards the different problems and socio-economic backgrounds of clients and the different personalities of clients and therapists than they are to deep theoretical differences. Some clients need handholding and have to sneak up on emotionally charged problems, while others can confront them outright and need "tough love." Some therapists are warm and sympathetic, while others are more comfortable in a critical role. Therapies also differ (at least officially) on how much they emphasize the past vs. the present; or on how short or long the term of treatment is; or how much the therapist steers the conversation vs. how much he lets the client take the lead. But despite these personality differences and varying combinations of basic therapeutic tools, apart from *radical* behaviorists who deny that we have cognitive states, almost all psychotherapists have the same basic intentional model, identified in Chapter Three – they posit representational states with which we interpret the world and act upon, a self or an ego, defense mechanisms, and so on. Some of them have slightly different models about the way the mind is organized sub-doxastically, but they are basically in agreement about the level at which they operate in clinical practice: we have beliefs and desires that cause us to behave, some of which are unrealistic and counter-productive and should be modified in the course of the therapeutic relationship. Therefore, an overview of psychotherapy as it is conceived and practiced by Freud, Rogers, and Ellis is likely to be representative of psychotherapy as a whole, so let's proceed.

To start with, we might very well wonder, how can the self be organized such that it can be tugged in such different directions as to become its own worst enemy? Freud, as we all know, had a model of the personality which accommodated such phenomena. In his view, we begin life with just an *id* (or set of instinctual drives for gratification), and gradually we develop an *ego* (whose function it is to develop a representation of the external world to both facilitate the instinctual demands, and protect the organism from danger by checking these impulses in accordance with the *reality principle*.[214] But by the age of five or so, another aspect of the personality comes onto the scene – the *super-ego*, a psychic agency which internalizes the values of our parents (or our caricatures of them) and takes over their functions: "it observes the ego, gives it orders, judges it and threatens it with punishments, exactly like the parents whose place it has taken."[215] Freud explains how this mental organization is susceptible to difficulties that require the services of a therapist.

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[213] C. Naranjo, "Contributions of Gestalt Therapy," (1971), quoted in Loew *et al.* (1975, p. 15). I will be saying a little more about Perls and Gestalt Therapy later on.

[214] As Freud explains in *An Outline of Psycho-Analysis* (1940, reprinted in **SE** XXIII, p. 199), when the ego operates according to the reality principle, it "comes to a decision on whether the attempt to obtain satisfaction is to be carried out or postponed or whether it may not be necessary for the demand by the instinct to be suppressed altogether as being dangerous." For a discussion of the Ego and the Id, see the work of that name in **SE** XIX; or see **SE** XX, pp. 195-200; or his *New Introductory Lectures to Psycho-Analysis* (**SE** XXII, pp. 76-77). In my terms, the ego is the self that self-ascribes *de se* attitudes, but *qua* subset of the person's cognition I would map it onto the person's notional world who interprets or perceives the phenomenal world.

[215] *Outline*, **SE** XXIII, p. 205. In the parlance I have adopted, in the process of developing a superego, part of the phenomenal field is assimilated into the phenomenal self when, instead of just acknowledging the judgmental opinions of "significant others," we are sufficiently impressionable as to adopt them as our own and incorporate them into ourselves. In other words, we learn how to nag ourselves with a judgmental agency that can not only *threaten* us with punishments, but it can also deliver them, with a variety of self-defeating symptoms and psycho-somatic ailments.

> According to our hypothesis it is the ego's task to meet the demands raised by its three dependent relations – to reality, to the id and to the superego – and nevertheless at the same time to preserve its own organization and autonomy. The necessary precondition of the pathological states under discussion can only be a relative or absolute weakening of the ego which makes the fulfilment of its tasks impossible. The severest demand on the ego is probably the keeping down of the instinctual claims of the id....But the demands made by the super-ego too may become so powerful and so relentless that the ego may be paralysed, as it were, in the face of its other tasks. We may suspect that...the id and the super-ego often make common cause against the hard-pressed ego which often tries to cling to reality in order to retain its normal state. If the other two become too strong, they succeed in loosening and altering the ego's organization, so that its proper relation to reality is disturbed or even brought to an end.[216]

Thus, it can be quite a balancing act, accommodating all these demands; no wonder we are subject to disorders and disturbances.[217] As Freud describes it, the conflict between the demands of reality, the id, the superego, and the ego struggling to maintain its own identity is like a civil war, and so the therapist's function is to strengthen the ego by helping it to marshal its resources better.[218] The goal of Freud's type of psychotherapy in particular, psycho-analysis, is to aid our egos in their struggles by helping them to "make conscious everything that is pathogenically unconscious,"[219] in order to precipitate[220] an emotional catharsis and a remission of the symptoms once patients acknowledge their psychological origin.[221] In all but the simplest cases, however, more than just interpretive insight is needed – analysts not only have to help people understand the darker motivations behind their behavior as the first important step to changing it, but they also have to help their egos cope with life's demands and (in Freud's view, but not mine) especially instinctual demands.[222] One way to help the ego win its "civil war" is through a kind of covert action that gradually vanquishes the overly hostile superego and replaces it with a more friendly power: the action is to familiarize the subject with yourself and your values. This is Freud's rationale for cultivating what he called "the transference relationship" (wherein a subject

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[216] *Outline*, **SE** XXIII, pp. 172-73. Concerning the loosening of the ego's organization, Freud adds, "We have seen it happen in dreaming: when the ego is detached from the reality of the world, it slips down, under the influence of the internal world, into psychosis."

[217] To describe struggle between the elements of the psyche, Freud himself invokes the famous triad of Plato's *Republic* when he likens the ego to a rider of a horse (see *The Ego and the Id*, **SE** XIX, p. 25). To complete the analogy: the rider (the ego, or reason, the head of state) struggles to retain control of the dark charging horse (the Id – the baser interests) and the overly conscientious white horse (the superego, the thought police, or guardians) that can tug too far in the other direction.

[218] See *The Ego and the Id,* **SE** XIX, p. 173.

[219] Freud, Lecture 18, "Fixation to Traumas – The Unconscious," in *Introductory Lectures on Psycho-Analysis* (1916-17), **SE** XVI, p. 282.

[220] Freud would like this word choice ("precipitate"), since he called his practice psycho-*analysis* because, as in chemistry, the object is to *analyze* symptoms down to their pathogenic unconscious and instinctual elements and then to restructure them into a more benign compound. See his "Lines of Advance in Psycho-Analytic Therapy," read to the 5th Annual Psycho-Analytic Society meeting, (1918) in **SE** XVII, pp. 159-60.

[221] This is what (allegedly) happened with Freud and Breuer's hysterical patients; see their *Studies on Hysteria* (1893-95) in **SE** II.

[222] E.g., in *An Outline of Psycho-Analysis* (**SE** XXIII, p. 148) Freud says "The forces which we assume to exist behind the tensions caused by the needs of the id are called *instincts*. They represent the somatic demand upon the mind. Though they are the ultimate cause of all activity, they are of a conservative nature..." However, in the neuroses we have been considering, which have been induced by abusing parents and terrible acts of violence, I would venture to say that our psychosexual feelings and development probably have very little to do with our current difficulties, particularly in PTSD, which is partially diagnosed, after all, in terms of the "Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone" (DSM-III 1980, p. 238).

relates to the therapist as if he were her parent, e.g.[223]): once the patient identifies with you as her father, she will assimilate your values in place of the more punitive ones she had introjected previously from her real parent.[224] When you recall the sets of values inculcated by the parents who abuse their children not only sexually and physically but also verbally (e.g., "You're no good!"), this approach makes a lot of sense. For people to develop basic self-esteem after such stunting experiences, we need to be assured that we are worthy human beings, and we can't just be *told* this, it has to be *demonstrated* to us by someone who is able to sustain a relationship with us without becoming disgusted or contemptuous. Furthermore, as Ferenczi noted above, after receiving such mixed emotions and perverse values (e.g., many abusing parents go on about the wages of sin even as they perpetrate their evil deeds, to convince both the child and themselves that it is the child who is responsible for her misfortunes) many victims internalize their parents' fanaticism *and* their guilt to compound their misery, so they have continued to abuse themselves in their parents' stead. Hence, the need for therapists to stop the old cycle and begin anew, by showing them respect and convincing them that they are decent and basically likable people, and supplying them with a healthier set of attitudes and values.

Now let's turn to Rogers' influential views on the goals of psychotherapy. Rogers has found that problems in adjustment arise when the phenomenal self is *threatened*, often by an acute discrepancy between the subject's perception of what he does, and what he'd like to think he is (i.e., when he feels his behavior fails to measure up to the self-image he is trying to maintain). This can happen when someone is "of two minds" about something, and they engage in behavior that part of them finds distasteful or shameworthy; e.g., "Gloria" in Rogers (1965) was a single parent who felt guilty about bringing dates home, where she lived with her young daughter. Therapy is often required to help resolve such ambivalences, especially when they result in symptoms after the person *denies* certain fundamental aspects of her experience.[225]

In accordance with Rogers' views about the phenomenal self's problems, his therapeutic goals are to alter the basic structure of the personality (1951, pp. 176, 186); to change its negative value attitudes to positive ones (1951, pp. 149-51); to update its view of itself to reduce the disturbing disparity between the perceived self and the ideal self (1961, pp. 64, 65, 36-38, 280-85); and, ultimately, to socialize it (1961, pp. 26-27). Rogers believes that the characteristics of a therapeutic relationship (which will be described shortly) will produce these personality changes:

> ... the individual will reorganize himself at both the conscious and deeper levels of his personality in such a manner as to cope with life more constructively, more intelligently, and in a more socialized as well as a more satisfying way....He changes his perception of himself, becoming more realistic in his views of self. He becomes more like the person he wishes to be. He values himself more highly. He is more self-confident and self-directing. He has a better understanding of himself, becomes more open to his experience, denies or represses less of his experience. He becomes more accepting in his attitudes toward others, seeing others as more similar to himself.

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[223] There will be more on transference below.

[224] See *The Ego and the Id* (**SE** XIX, p. 175): "If the patient puts the analyst in the place of his father (or mother), he is also giving him the power which his super-ego exercises over his ego, since his parents were, as we know, the origin of his super-ego. This new super-ego now has an opportunity for a sort of *after-education* of the neurotic; it can correct mistakes for which his parents were responsible."

[225] For example, Rogers (1951, pp. 147-48) sketches the case of a woman who faints at times that are most embarrassing to her husband, thereby unconsciously expressing her antagonism toward him.

> In his behavior he shows similar changes. He is less frustrated by stress, and recovers from stress more quickly. He becomes more mature in everyday behavior as this is observed by friends. He is less defensive, more adaptive, more able to meet situations creatively.[226]

This, then, is what psychotherapists aim to do, and how they rationalize it. Now let's examine in more detail how they actually set about accomplishing these goals of overturning subjects' "basic self-sabotaging philosophies" (as Ellis [1971, p. 2] puts it) and fundamentally restructuring their personalities. The remainder of this Section will explicate the principles and methods of the tradition I am calling "notional world psychotherapy,"[227] focusing especially on the characteristics of the therapeutic relationship itself, and the contributions of these same influential therapists.

Understanding and Treating Psychological Disorders in Notional World Terms

As we just saw, when life deals us hard knocks, we sometimes develop psychological problems that need help. In this Section, I will draw on the expert testimony of intentional psychologists to show how the notional world model is put to ***use*** in some of the major schools of "notional world" clinical psychology, which set about identifying and correcting some of the problems that can arise when an individual's notional world is not centered enough, or when there is a misfit between it and the external world.

Crudely put, the emotionally disturbed distort or magnify things out of proportion, and watch disturbing internal movies; given what they think the world and themselves are like, their feelings and behavior *are* appropriate.[228] As we'll see, according to such leading experts in the field of neuroses as Sigmund Freud, Carl Rogers, Albert Ellis, and untold others, often as not, the investigating therapist finds that many of our psychological disturbances are sustained by negative or unrealistic attitudes about the self or the world. Accordingly, psychotherapy's goal is to correct our difficulties by building up our self-esteem and making our attitudes more realistic or adaptive. To overcome their difficulties, many subjects need therapists to help them to identify, understand, and modify their maladaptive conceptions of the world and themselves, as I shall explain, beginning with a more detailed exposition of the psychotherapeutic rationale.

The Psychotherapeutic Rationale

Why should content-based *psychotherapy* be used to treat people with psychological problems? An important ***negative*** reason, which was recognized by Freud, an accomplished and experienced neuropathologist and physiologist, is that in many cases, alternative medical treatments

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[226] "Some Hypotheses Regarding the Facilitation of Personal Growth," in Rogers (1961, p. 36).

[227] Of course, this is just a fancy way of saying "applied folk psychology," but I call it "notional world" psychotherapy because, as we saw in Chapter Three, its adherents explicitly endorse a notional or phenomenal world model.

[228] For example, despite his average build, at some times the manic-depressive sees a "wimp" in the mirror, at others – a Hercules! And while we see an anorexic girl as an attractive, albeit skinny person, she sees herself as a fat and hideous lump – a thing.

simply don't *work* well;[229] this remains true today, as I shall explain in detail in Chapter Seven, since somatic treatments continue to have limited efficacy and severe side-effects. But there's also a ***positive*** reason for supposing that psychotherapy is the most appropriate mode of treatment in many cases of psychopathology, which shall be explored in this subsection, and Freud also recognized, after working with hysterics: meaning matters! Many of our symptoms are *symbolic* of psychic disturbances, and there are *reasons* behind our maladaptive behavior, reasons which must be recognized and understood to be changed.[230]

Although this positive line of argumentation establishes at best a *prima facie* case for the use of intentional therapies rather than a conclusive reason, since the questions of etiology and treatment are somewhat orthogonal,[231] the primary rationale for using psychotherapy is the claim that many psychological problems are either caused or sustained by content-bearing psychological states such as low self-esteem which are best addressed *and* influenced at the psychological level. Psychotherapy attempts to alleviate such problems by helping the subject to identify, understand, and "work through" these psychological factors, as we shall see below. To be sure, both content-bearing states and "architectural" ones such as our anatomical structures or neurochemical balances are types of physical states, but if the former are responsible for the unwanted symptoms, then intentional psychology and psychotherapy are probably the appropriate means of understanding and treating such problems.

As the intentional psychologist views matters, then, psychological disorders are not really "medical" or organic deficiencies at all; rather, they are the outcome of various "problems in living," as Szasz (1961) calls them, which we have resolved poorly, and the symptoms we develop (such as phobias, hysterical paralyses, violent behavior, etc.) are the results of our inner struggles and conflicts. In other words, they are ***psychogenic*** in nature, or caused by psychological factors. However, we don't bring all the misery upon ourselves, of course; as we're about to see, we can be deeply affected by what others say and do to us, and we are sometimes traumatized by natural and accidental catastrophes, as well. But whatever precipitated them, the *current* source of our psychological difficulties is inside us, sustained by our thoughts and feelings, according to this view. Just as some overprotective parents work themselves into hysteria by worrying when their children are late coming home, others' problems are caused by their intentional states (self-criticism, insecurities, nightmares, fears, hostile wishes, and so on), as we shall see in more detail below.

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[229] As Freud puts it, "Psycho-Analysis was born out of medical necessity. It sprang from the need for bringing help to neurotic patients, who had found no relief through rest-cures, through the arts of hydropathy or through electricity." (Freud's Preface to Reik's *Ritual: Psycho-Analytic Studies*, reprinted in **SE** XVII, p. 259.) In the Chapter Seven, we shall see that both psychiatric and general medicine *still* needs psychotherapy's services.

[230] E.g., see *Studies on Hysteria*, (1893-95), by Freud and Josef Breuer in **SE** II, or Freud's "A Short Account of Psycho-Analysis" (1923) in (**SE** XIX, pp. 191 ff.). I will be returning to these pivotal episodes in the history of psychiatry in Chapter Six.

[231] Whether psychopathology is due to genetically mutated brain function or faulty or bizarre ideation, the two types of problems (architectural and ideational) might be served best by either physical therapy or talk therapy or by a combination of both. Perhaps faulty ideation can become normalized by drugs, even as normal ideation can become bizarre when influenced by drugs, including the psychotropic drugs administered to prevent these very conditions. Alternatively, perhaps even abnormal chemical balances can become more regular via the influence of psychotherapy. I will return to these issues in more detail in my (forthcoming).

Supposing for the moment, then, that these *are* problems of content as the psychological model maintains, I should now explain the rationale for thinking that knowing the intentional content relevant to the condition might do us any good. In other words, how is a content- and reason-based approach to be of any service? Presumably, the goal of a content-based therapist is the same as a syntactic psychiatrist's would be: to elicit a beneficial change in subjects' functioning, to bring them and others around them a better life. Since our psychological states supervene on our physical states (according to both parties to this dispute: see Chapter Three, and Stich 1984, 1984b), ultimately, corrective therapy has to affect our internal circuitry or physiology. The question is, how can the requisite alterations in our physiology be made so that we have a more adaptive psychology?

Given the values that constrain the socially permissible range of treatments, the least invasive and potentially damaging of comparably effective treatments is to be preferred. Thus, it is preferable to at least *try* to restructure the subject's cognition *via* content before adopting alternative methods such as psychosurgery (unless the problem is clearly due to some physical abnormality such as epilepsy or a tumor), mind-numbing drugs, or brain-washing conditioning, each of which have the serious potential to assault personal autonomy and cause permanent harm. But we do want a re-wiring (or 'a change in the weights') of the subject's psychological network. Content-based (or "talk") therapy attempts to bring about the needed restructuring via factors *within* the subject, by speaking to the attitudes themselves. Change people's attitudes, and their behavior will change, and with it, the way people interact with them, and we may all become better off. Psychotherapy helps people to *change their minds* about things not by assaulting their brain, but by [*persuading* them to construct a new notional world or set of attitudes about what they perceive. Psychotherapists are trained in the business of restructuring the cognition of subjects *via*, i.e., *in virtue of* (to adapt Fodor's 1980 phrase) content, using understanding, communication, and persuasion to help us to develop more adaptive attitudes and take up better ways, as I shall explain in more detail presently, after first articulating the therapeutic goals of some of the major psychotherapists in a little more detail.

Overview of Notional Attitude Psychotherapy

As I indicated in Chapter Three, for clinicians working within the notional world paradigm, the rationale for adopting the subject's perspective when it comes to doing individual psychology is clear: behavior is structured and caused by the individual's conceptions of the world, so the proper objects of clinical inquiry and intervention are the individual's own conceptions; e.g., as Carl Rogers (1951, p. 40) writes in his Client Centered *Therapy*,

> ...it is the counselor's function to assume, in so far as he is able, the internal frame of reference of the client, to perceive the world as the client sees it, to perceive the client as he is seen by himself, to lay aside all perceptions from the external frame of reference while doing so, and to communicate something of this empathic understanding to the client.

But how do psychotherapists go about discovering what is troubling us? As Rogers in particular has noted, in order to achieve a mutual understanding of the subject's notional world, a good therapist has to provide a "safe" relationship in which clients are willing to explore their feelings with the active participation of someone who is both concerned and sensitive enough to help them come to a better understanding of themselves and try to improve their lives.

The successful psychotherapeutic relationship involves both "do's" and "don'ts;" we'll start with the latter. Breaking away from the strictures of orthodox Freudian psychoanalysis, Rogers maintains that therapists mustn't come at the individual with a lot of theoretical preconceptions – they should reflect what the subject is *really* feeling, not what their theory says they *should* be; e.g., they shouldn't look for unresolved Oedipal complexes all the time. Nor should they grill subjects like a District Attorney,[232] or treat them as objects or faulty machines.[233] Rogers also takes exception – with good reason – with psychoanalysts' practice of being officially aloof, dispassionate, and removed.[234]

Instead, in Rogers' view, the therapeutic alliance should be an "I/Thou"[235] relationship of mutual respect. Therapists must *understand* the person, not judge him (1961, p. 18), and he calls upon therapists to bring *congruence* to the relationship, by being "real" or "genuine" and not putting on phony airs to mask their personal reactions.[236] Congruence in an extremely important facet of human relationships – we want to know when someone is "on the level" or sincere before we will trust them with our feelings. When congruence is lacking, and the therapist vehemently denies that he has been irritated by something, for example, this can exacerbate the condition of

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[232] Rogers (1961, p. 11) writes that after working as a clinical child psychologist for a few years, he became "appalled" after re-reading a transcript of "a clever legalistic type of questioning by [an] interviewer which convicted [a] parent of her unconscious motives, and wrung from her an admission of her guilt. I now knew from my experience that such an interview would not be of any lasting help to the parent or the child."

[233] See Rogers' interview in Evans (1976, p. 228). Mind you, Rogers doesn't think we're *not* machines, it's just that you get better results if you don't treat us that way. In fact, even this quintessentially Humanistic psychologist endorses (at least provisionally) the Computational Theory of Mind when discussing the way we process information and selectively attend to things (see Rogers 1961, p. 190).

[234] This dispassionate pose of "uninvolvement" is one of the primary aspects of psychoanalysis that differentiates it from other species of therapy; e.g., see Maurice Dongier, "Is Psychoanalysis a Psychotherapy?" [he says yes], in Dongier and Wittkower (1981, p. 143). Psychoanalysts are even removed from the patient logistically: they have the patient lie on the coach, and sit behind them, out of their view. For your information, Dongier (*ibid*.) cites the other three factors specific to psychoanalysis. One is the "Timelessness and intensity of the treatment," since unlike short-term therapy it is not initiated with a prearranged time limit; however, Dongier acknowledges that this "timelessness" often cashes out (literally) as an interminable duration to analysis, since it "may help create indefinite dependency in spite of all attempts to analyze the transference neurosis." Because it stresses free association, another specific factor is its "*Absence of focus,"* allowing the analysand to leave no stone unturned in his whole inner world, which may maintain the patient's resistance and encourage interminable analysis." The last factor, which is perhaps the most perverse in this field that is supposed to be concerned with the subject, is its "Exclusive concentration on transference and other derivatives of the unconscious fantasies," i.e. it focuses on what the patient thinks of the doctor.

The extreme aloofness of the therapist; the almost exclusive concentration on how the patient perceives and relates to the therapist; the interminable duration; the use of the couch and free associations, which encourage fantasizing and dependency (e.g., see Way [1950, p. 230]: "The position is sexually suggestive and heavy with a half-dreaming influence. It is no wonder if this technique produced strong transference reactions which had to be cured before the patient was fit to go out into the world."); and the tendency to dismiss abuse victims' reports of actual episodes as *fantasies* and dark Oedipal wishes (see my Appendix A) – it seems that all of the factors specific to psychoanalysis are potentially quite counter-productive; yet even now it has adherents. In one of his "Papers on Technique" (in **SE** XII, p. 323), Freud himself says, "Psycho-analysis stands or falls with the recognition of the sexual component of instincts, of the erotogenic zones and of the extension thus made possible of the concept of a 'sexual function' in contrast to the narrower 'genetic function'." However, if that's what's central to analysis – the emphasis on psychosexual instincts and erotic zones – then let it fall; he says studies of children's sexuality bears it out (*op. cit.*, pp. 323-26), but adults have other things on their minds, as do children.

[235] Rogers often invokes this "I/thou" phrase of the Existentialist theologian, Martin Buber, e.g., in Evans (1976, p. 220).

[236] See, e.g., Rogers (1961, pp. 61, 339-42). Rogers finds that it's okay to express your feelings about what clients are telling you, so long as it is not in a way that imposes itself (see Rogers 1965).

schizophrenics, who are extremely sensitive to such discrepancies or attempts at dissembling.[237] Rogers also believes therapists should show their clients *unconditional positive regard*, to give them emotional support in terms of encouragement, caring, and concern, no matter what they reveal about themselves, in order to give them the motivation to *want* to change,[238] to undertake the process that Rogers (1961) calls "becoming a person."

Keeping these characteristics of the therapist's congruence or sincerity in mind, let us go on to see how a helping relationship's investigation proceeds.

The Psychotherapeutic Investigation

First and foremost, the normal course of the therapeutic relationship and process of change involves the client communicating information about himself in order for the therapist to come to understand him. Whether it's a psychoanalyst sitting back and letting a patient on the couch free-associate, or a counselor sitting face to face asking a person direct questions about personal matters, the bulk of therapy is spent in getting subjects to talk and think about themselves.

Free-association is the 'technique' of having subjects say whatever comes into their mind. This isn't a waste of time, because it reveals individuals' notional worlds, and it can be very revealing when something is *not* said – when they abruptly stop talking or switch topics. Most therapists accept Freud's idea that there are *unconscious* aspects of the personality that defend the ego or protect the self-image by mechanisms such as *denial* or *repression*, which are manifested when the client stumbles into a problem area of the personality and the 'free' associations are blocked or held back.[239] However, free association may not always be the best method for getting people to honestly open up about themselves – sometimes it encourages people to fantasize instead of concentrating on what's really going on in their lives. This isn't surprising, since Freud confesses that he got the idea of free association from Ludwig Borne's "The Art of Becoming an Original Writer In Three Days."[240]

When free-associations are blocked or going nowhere, or when a non-directive approach such as Rogers' doesn't proceed at a satisfactory pace, the therapist can ask them direct questions; e.g., "Are you a homosexual?" However, such probes into sensitive areas of their lives can evoke considerable anxiety in clients, and tend to be counter-productive – the angered, indignant, or ashamed client might break off the interview and the treatment. Skillful interviewers such as Harry Stack Sullivan (1954) know how to draw out some of the attitudes crucial to the

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[237] On the effects of incongruence, see, e.g., Schulz and Kilgalen (1969, pp. 156-57), and Rosenhan and Seligman (1984, pp. 491-92) on disturbed communication patterns in schizophregenic families.

[238] Rogers (1961, pp. 283-84); or see Bernstein and Neitzel (1987, pp. 294-97).

[239] Most therapists recognize levels of awareness, including unconscious processes. Apart from Freud, of course, there's Rogers (see his [1951, p. 438], or his interview in Evans [1976, p. 215]); Aaron Beck (whose "Cognitive Therapy" we will examine in Chapter Seven; see his [1976, pp. 30-34, 318]); and Ellis (1971, pp. 1-2), who states that his Rational Emotive Therapy "not only quickly reveals to the individual many important things of which he is, at best, only dimly aware, but it almost immediately begins to undercut and disembowel the conscious and unconscious irrational assumptions that make him and keep him emotionally disturbed." I will be discussing the defense mechanisms I mentioned in more detail in Chapter Six.

[240] See Freud's *Beyond the Pleasure Principle, Group Psychology, and Other Works* (1920-22), **SE** XVIII, pp. 264-65, where he anonymously confesses where he got the idea of free-association.

personality: he asks questions, but does not doggedly pursue sensitive issues with blunt, direct questioning, since "most topics of human living are so interlocked that you can approach the same thing from six or seven different directions" (p. 211). As we shall see later, such interviewing skills are quite important.

When merely being there for clients and being a kind, empathetic, good listener who can reflect what they are feeling does not elicit sufficient material to make progress, a little prodding may be needed to find out what other maladaptive characteristics they have but haven't brought forth voluntarily. Sometimes clients don't really *want* to change even though they're going to a therapist, and they just play "mind games" with the therapist and conceal what's really troubling them. In such cases, the therapist has to push them a bit to help them to get more productive lives. It's important to get them to focus on their *present* feelings and experiences rather than to merely report past events.

One way to get them to do this is to have them *role-play* the parts of important people in their lives, or aspects of themselves they are ambivalent about.[241] As might be expected in a notional world framework that emphasizes scripts and roles, psychotherapists use this technique of role playing or *psychodrama* both to get subjects' true feelings about others out in the open, and, as we'll see below, also to help them vent and "work through" these feelings.[242]

There are other sources of information about the subject, as well, such as "body language": the subject's posture, nervousness, movements, and facial expression can belie his verbal expressions.[243] *Dreams* can also be important, because they aren't simply mental sewage or epiphenomena, they are often attempts by our psyche to deal with the problems of self-doubt, reproach, and recrimination that gnaw at us.[244] Often, no 'deep' analysis is required, and it's manifest in the dream content what the person's problem is, as when veterans relive their moment of cowardice or horror in combat over and over again.[245] *Hypnosis* can be useful, too,

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[241] See Perls (1965) and Bernstein & Nietzel (1987, 305 ff.) to see how Fritz ("Gestalt Therapy") Perls bullies clients who just come to learn how to play their neurotic games better, or who expect him to give them 'a magic pill or something.' See also Perls (1965).

[242] Psychodrama can be very instructive and useful: you get the subject to act out parts, to play someone else,, to try to adopt another's point of view. They write the dialogue and script the part, thereby showing their notional world and the way they regard the characters in their life. When their views (e.g., that they regard their father as a tyrannical despot, or as a saintly man) are thus brought out into the open, the subjects and the therapist can examine these views for their soundness and cogency. (E.g., "He's not such a bad guy....)

[243] Fritz Perls' "Gestalt Therapy" is especially noted for paying attention to non-verbal clues, but most perceptive interviewers are sensitive to them.

[244] E.g., see Adler (1930), Way (1950) and Sonnenberg *et al.* (1985) on the function of dreams.

[245] Most traumatized people are plagued by nightmares about what they consider their worst moments; it is one of the official symptoms of PTSD (see DSM-III 1980, pp. 236-38). And although it was a difficulty for his theory since he held that psychological problems originate in problems of childhood development and that dreams were wish-fulfillment (e.g., in *The Ego and the Id* [in **SE** XIX, p. 127], Freud says, "Our mental activities pursue either a useful aim or an immediate yield of pleasure....Now, dreaming is an activity of the second kind, which is indeed, from the point of view of evolution, the earlier one ... A dream may be described as a piece of phantasy working on behalf of the maintenance of sleep.") even Freud recognized that traumatic dreams – which do anything but give us a contented sleep – have a special function. See Sonnenberg (1985, p. 17):

"Paradoxically, Freud considered the "dark and dismal subject" (p. 5) of traumatic neuroses to be a separate phenomenon from neuroses whose foundations lie in childhood. In *Beyond the Pleasure Principle,* he treats the nightmares that almost always accompany traumatic neuroses as entirely separate phenomena from normal wish

for uncovering repressed and forgotten episodes from their past. And symptomatic acts like 'parapraxes" or "Freudian slips" can indicate blockages and barely repressed wishes and the like.

In addition, subjects' diaries, writings, and creative works can be informative. Indeed, the texts of the afflicted chronicling their inner world are the most informative source of information about madness that we have,[246] which is no surprise, considering their problem just *is* having a confused or tortured inner world. Furthermore, there are tools of clinical investigation such as Thematic Apperception Tests (TAT's), which are pictures of ambiguous scenarios which the client interprets, thereby exhibiting the "scripts" or "frames" with which he or she approaches the world.[247] Moreover, I should also emphasize that the symptoms themselves may be disguised communications which can be illuminated by discerning investigators' interpretations.[248]

As Freud recognized (and perhaps fixated upon), another important source of information is the course of the therapeutic relationship itself, especially the phenomenon he called *transference.* Patients often re-enact their problems of adjustment in the course of their relationship with the therapist, and transfer or project their (or more often, their parents' or spouses') motivations onto him or her.[249] Freud notes that apart from facilitating the introjection of a better set of values for the superego, the other benefit of transference is that "in it the patient produces before us with plastic clarity an important part of his life-story, of which he would otherwise have probably given us only an insufficient account. He acts it before us, as it were, instead of reporting it to us."[250] The therapist should be attentive to such things as whether the client habitually comes late to sessions (which might be an expression of adolescent rebellion), or if he fails to come at all

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fulfillment dreams. He argues that nightmares that follow trauma represent the psyche's repeated attempts to master a situation that has overwhelmed the defenses. But these distinctions appear to have been overlooked by his followers, who maintain that a defense system cannot have been adequate in the first place if it was so permanently disabled by a catastrophic event."

Sonnenberg points out that such misguided allegiance to Freud prevented the recognition and adequate treatment of PTSD even as late as 1980.

Furthermore, it's probably not the case that non-traumatic dreams are all wish-fulfillment. Many neurotic people who feel they should be superhuman flagellate themselves for their weaknesses in their dreams, and they have insecurity dreams such as appearing naked in public, etc. They can take sedatives to ward off these demons, sedatives that suppress REM sleep, but when the drugs are stopped they come back with a vengeance – there is a rebound reaction with increased periods of REM, nightmares, and a relapse of the anxiety upon withdrawal of anxiolytics. See, e.g, A.D. Korczyn, "Hypnotics and Sedatives" (in *Meyler's Side Effects* [Dukes 1980], p. 62):

"Although insomnia is one of the major indications for use of these agents, it should be stressed that the sleep induced is abnormal, being deficient in stage REM. Moreover, one of the withdrawal symptoms following prolonged use is excess of REM sleep, being manifested as vivid and unpleasant dreams and subjectively nonrestorative sleep, which in turn cause the patient to resume drug consumption."

It seems as if the super-ego has to catch up on all the lost opportunities to abuse the sleeping ego, as people routinely suffer torrents of nightmare when the drugs are discontinued. We have to deal with our psychic demons directly; drugs only make them – and us – dopey and ineffectual.

[246] E.g., see the non-fictional collection *The Inner World of Mental Illness*, (Kaplan 1964), which includes such classics as Clifford Beers' "The Mind that Found Itself" (which precipitated the mental hygiene movement to curtail some of the mistreatment in psychiatric institutions earlier this century; see, e.g., McNeil and Rubin (1977, p. 462).

[247] See, e.g., Bernstein and Neitzel (1987, pp. 146-50) on TAT's.

[248] See Freud, Szasz, Breggin, Glasser, or any of a host of others on how to read symptoms such as phobias as disguised communication. Even masochism is a communicative act: see Schulz and Kilgalen (1969, p. 123).

[249] See Reber (1985, pp. 785-86); and Fancher (1973, pp. 176-79).

[250] In Freud's *An Outline of Psycho-Analysis* (1940), Part II: The Practical Task, Ch. VI, "The Techniques of Psycho-Analysis," **SE** XXIII, pp. 175-76.

(*absenteeism* is repression writ large when the subject skips sessions after the therapist gets too close to sensitive areas). And, finally, the patient is not the only source of information about himself – the therapist doesn't always just have to wait for the subject to remember what has happened to him, as Freud points out, since he can always make enquiries about them to family and friends.[251]

As I've already indicated, the clinicians who conduct these therapeutic investigations frequently discover that the root cause of their clients' problems is low self-esteem, or anxiety over the discrepancy between their perceived self and their ideal self. But now let's consider how the personal relationship afforded by the therapist is supposed to help.

The Psychotherapeutic or Helping Relationship

In Rogers' opinion, the therapeutic alliance or "helping relationship" alone should be enough to solve clients' problems, assuming the therapist has the attributes delineated above (realness or genuineness, empathy, and unconditional positive regard), which he hypothesizes as being jointly necessary and sufficient for bringing about therapeutic change.[252] The hope is that clients in such relationships will "grow" or become more of a person once they know someone cares and they get to know themselves better. The theory is that we've all got this fundamental capacity for change or potential for growth, but when our personal growth has been hampered by factors such as perceived threats to one's phenomenal self, the therapist can facilitate it through the nurturing climate provided by his or her attributes. Because they feel prized by the therapist (who's a nice, intelligent, sensitive person), clients will come to prize themselves more; the therapist's acceptance of them – despite knowing about the aspects of themselves they are ambivalent about or deny – should help them become more integrated.[253]

In Rogers' favor, it is hard to exaggerate the importance of the therapeutic relationship for the client's progress. Not only does it illustrate the way clients perceive and interact with others, but it is also the source of succor, support, and courage to give the client the incentive to change, and

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[251] See Freud's Lecture 18 on Psycho-Analysis: "Fixation--The Unconscious," in **SE** XVI, p. 281: “One can make enquiries about these experiences from the patient's relatives and they will often be able to recognize which of them had a traumatic effect, and they can even sometimes report experiences of which the patient himself knows nothing because they occurred at a very early period of his life.”

The problem with this method, of course, is that too often the relatives and family friends you make enquiries to are the very ones who abused or disturbed the subject, and they are not likely to be very forthcoming with helpful information. It is probably a better idea to talk to the client's neighbours.

[252] E.g., See Rogers' "The Necessary and Sufficient Conditions of Therapeutic Personality Change," *Journal of Consulting Psychology*, 21, 1957, 95-103.

[253] See "On the Facilitation of Personal Growth" in Rogers (1961, pp. 31-38), and Rogers (1965). Here Glasser (1960, pp. 164-65) describes how a Rogerian therapeutic relationship can foster personal growth in terms of drawing "ego strength" from the therapist:

“There must be a warm, human, intimate relationship between the psychiatrist and the patient. The patient must perceive that the therapist is a person whom he can trust, who wants to help the patient for his own sake, and who will not desert him when he unburdens his difficulties....The therapist does not lecture, exhort, or direct him; nor does he fear the patient, misguide him, show anger toward him, laugh at him, or judge him. Warm and friendly, never hostile...the entire relationship is a new experience in which the patient's old and poor defenses do not work and in fact are not even necessary. In the new relationship the patient is free to let his ego grow in the absence of pathological defenses....In his treatment of the patient he consistently shows kindness and strength so their relationship has a solid base on which to grow. The patient's ego can never develop more effective functioning in an inconsistent relationship.”

it also provides a direction for growth, as the client can model his personality to be more like the therapist's (which, hopefully, is more 'together'). But is such a fostering climate *enough*? Even if the client undergoes some personality reorganization as the result of the therapist's concern, it may not be enough to make him an autonomous, effectively functioning person, as Ellis argues.[254] On Ellis's view, you can't just give clients gobs of love, you have to get them to think for themselves, because you won't always be there for them, and so you have to understand their thinking to know what changes to try to make. For Ellis, the goal is to get the client to bring the locus of evaluation inside – to judge for himself whether his activities are acceptable or he is worthy.[255] Let's briefly see how this is done, in more insight-oriented and directive therapies than Rogers' official version of non-directive Client-Centered Therapy.

Let's start with the psychodynamic approach, which emphasizes the role of unconscious conflicts in the etiology of neuroses.[256] The psychodynamic view of neuroses such as obsessions or hysteria is like Socrates' theory of vices, as Freud himself observes,[257] since they both result from a type of ignorance and need to be corrected through understanding. To alleviate the distressing symptoms, the therapist has to discover the unconscious memories, wishes, or unresolved conflicts that are producing the disturbances, and then bring them to the patients' conscious attention to try to effect a cure. In simple cases, sometimes the very act of interpreting such symptoms and thus bringing their symbolic and psychic function to the light of consciousness is sufficient to dispel the symptoms – a process called "catharsis."[258] In general, however, merely achieving insight into the nature of their problems isn't usually sufficient; as Glasser (1960. p. 167) puts it, "insight into the defective ego functioning does not help any more than does the understanding that Sam can't walk because he has a broken leg. This information is good to know, but much correct therapy is needed before Sam can walk." To help us "walk" better, one important process is known as "*working through*" the ambivalent feelings and defenses: the client has to learn how to recognize their existence and the extent of their influence; how to check their influence; and ultimately, how to resolve them.[259] For example, the victims of incest

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[254] E.g., Ellis (1971, p. 5) writes, "... the "successfully" treated Rogerian client normally gains "self-esteem" or "ego-strength" by entering therapy with the irrational idea, "I am no good unless other people accept or love me," and leaving therapy with the slightly better but still basically insane idea, "I am worthwhile because my therapist cares for me, and presumably others can care for me as well." It is exceptionally difficult to see how this client has gained any appreciable kind of unconditional positive self-regard."

[255] To be fair to Rogers, however, he says the same thing, e.g. in the "Gloria" film (Rogers 1965).

[256] Although Freud himself thought that the pathogenic conflicts are all psychosexual in nature (see my Chapter Six), his psychoanalytic approach is but a species of psychodynamic psychotherapy, as Adler and others who broke with him have demonstrated. And although classical hysteria is no longer prevalent, the psychodynamic interpretive approach can be extended to traumatic life events in general. As examples of ostensibly non-sexual cases of neuroses induced by trauma or underlying conflicts, see Rosenhan and Seligman (1984, pp. 206, 136-37), who describe one woman who had an extremely hampering snow phobia because she was buried at age 11, but had repressed the memory; and a man who developed hysterical blindness as the result of guilt over a rival's death and being reminded of it every year.

[257] See Freud's Lecture 18 on Psycho-Analysis, "Fixation – The Unconscious," **SE** XVI, p. 281. I will be exploring the commonalities between Socrates' and Plato's approaches in a great deal more detail in Chapter Six.

[258] The psychoanalysts call this process "catharsis" after the process described in Aristotle's *Poetics*, which claims that it is essential to good tragedy that it produce a purging of emotions in the audience when they see the hero they had identified with fall as the result of his *hubris* or fatal flaw.

[259] On "working through," see Fiaklow and Muslin (1987); or Bernstein and Neitzel (1987, p. 236): "The patient needs to understand how pervasive the unconscious conflicts and defenses are so that he or she can learn to recognize them and prevent their return. It would do little good for a patient to know that she had unconscious feelings of anger toward her

we heard about in Section One have to recover the memories they are blocking out, and work through their feeling of guilt and shame, by redirecting their anger from themselves to the individuals who harmed them. They have to learn how to blame the adult, and more importantly, how to stop blaming themselves, before they can develop some self-respect and actually *like* themselves and have closer relations with others; but they can't just *say* they're not to blame – they have to *mean* it.[260] In many cases, it is also important for them to resolve their feelings about whether to blame the passive parent who let it go on.[261] In such cases, psychodrama is sometimes an important therapeutic process, to let them "act out" some of their hostile feelings, or get them to see others' point of view regarding their blameworthiness. Similarly, when dealing with veterans wracked by guilt or shame who are compulsively reliving their combat experiences in disguised form,[262] you have to try to convince them that their actions were honorable, or that anyone else would've done the same thing in those circumstances after they'd been through what he had to endure.[263]

When such repressed or maladaptive attitudes have been successfully "worked through," they can be replaced with new and more adaptive ways of responding to people. But how is this "working through" to be achieved? Through *reasoning*! As a paradigm case of reasoning therapy, consider Ellis's Rational Emotive Therapy, or RET, which he characterizes as,

> ... a Socratic-type dialogue through which the client is calmly, logically, forcefully taught that he'd better stop telling himself nonsense, accept reality, desist from condemning himself and others, and actively persist at making himself as happy as he can be in a world that is far from ideal.
> (Ellis 1971, p. 4)

Ellis's style thus contrasts sharply with Rogers' – his is *tough* love, which cuts clients no slack, and even seems *mean*.[264] Even Rogers, however, acknowledges that such approaches can work,

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mother if she did not also see that she deals with women in the present as if they were her mother, and that her problems in relation to these women are based on unconscious hostility and/or attempts to defend against it."

[260] See Forward (1984), e.g., pp. 167, 170.

[261] Forward (1984), pp. 48, 59, 166-68.

[262] Regarding incidents that re-enact combat experiences, see Sonnenberg *et al.* (1985, pp. 3-5 and 298-300) on hostage-taking incidents; or for a description of someone who set fire to his own kitchen to burn out the VietCong, see Hendin (1986, p. 93).

[263] See Smith, in Sonnenberg (1985, p. 128): "Trauma consists of experience which an individual cannot integrate with some cherished aspect or significant notion of self, of others, of the world, or of morality. Such discrepant experiences are dissociated and placed out of awareness. They may periodically threaten to intrude or exert unconscious influence on the individual's current activities. Warding off or walling off the effects of discrepant experience also hampers or restricts current functioning. Adaptive intermediate resolution results in assimilation of some traumatic experience and the isolation of undigested experience so that current functioning remains relatively intact. Full resolution, however, involves the transformation of existing cognitive and affective structures to permit the accommodation of discrepant traumatic experience."

Trauma is a kind of psychic heartburn, then: some experiences just don't go down right, and to get relief from the resultant excess emotional tension, many need a facilitative relationship with a therapist to get it to fizz to the surface to be dissipated.

[264] For example, Ellis sings his clients songs such as "I cannot have all my wishes filled / Whine, whine, whine!" (Ellis 1985, p. 24), and one of his RET therapists tells a neurotic teenager that his worries are *idiotic* and that the world doesn't give a shit so stop crying about it. (H. Jon Geis, "RET With a Culturally Deprived Teen-Ager," in Ellis (1961), pp. 46 ff.

as long as they are *sincere*.[265] RET therapists try to undercut some of the moral and emotional resonances behind their clients' insecurities and irrational fears by both actively disputing whether what they're worried about is true (e.g., are they really "worthless" because they failed some test?) or likely to obtain (e.g., becoming homosexual), and trying to convince them that even if it were, it wouldn't be so *awful* (e.g., see Ellis 1971, pp. 103, 165). They also attack the hopelessly idealistic expectations that make people feel unfulfilled, despite having relatively decent lives, such as "love myths" like "s/he's got to be perfect;"[266] and their 'antidote' to pathological ideation such as "It's *horrible* when the world is rough," is to convince us of the wisdom of responses such as "tough luck" (cf. Ellis 1971, p. 10). The goal, of course, is to overturn our "basic self-sabotaging philosophies" (Ellis 1971, p. 2) and help us to develop a more adaptive set of attitudes and expectations about ourselves and the world. And since Ellis, like many other therapists, thinks that irrational beliefs and expectations are often our main problem, and that perfectionism is thus at the root of many psychological evils, the RET therapist takes on the role of a teacher or a frank counter-propagandist,[267] to go after the "tyranny of the shoulds" (such as "You should be liked by everyone and good at everything"), which are irrational and maladaptive.[268] Finally, it should be noted that other therapists concur with Ellis that psychotherapy has a frankly educative function, as needs be the case if we are to socialize people or teach them the folly of their ways; e.g., Thomas Szasz (1961, p. 240), who is a type of psychoanalyst, maintains that the point of psychoanalysis is to teach people the rules to the game of life, rules they violate or can't quite grasp.

That should give us an ample idea of how content-based therapy goes about helping people with their psychological problems, then; now let's consider a contrasting approach, which would attempt to do away with the need to interpret the content of troubled or unhappy people's experiences.

Stich's Syntactic Theory of the Mind

In the series of publications which constitute his "Case Against Belief,"[269] Stephen Stich has drawn upon the work of W.V.O. Quine, Donald Davidson, and certain other philosophers of language to shed some light onto the process of content ascription. Although he, too, exploits Twin-Earth intuitions, as we shall see, part of his analysis is in keeping with what Rogers and other psychologists have said about the nature of empathic understanding. In brief, Stich argues that the process of content ascription is tantamount to performing a kind of skit or "pretend

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[265] As Rogers (1962, p. 9) puts it, "...therapy has to do with the *relationship*, and has relatively little to do with techniques or with theory and ideology...it is the *realness* of the therapist in the relationship which is the most important element. It is when the therapist is natural and spontaneous that he seems to be most effective...sharply different therapists achieve good results in quite different ways. For one, an impatient, let's-put-the-cards-on-the-table approach is most effective, because in such an approach he is most openly being himself. For another, it may be a much more gentle, and more obviously warm approach, because that is the way *this* therapist is."

[266] One of RET's primary applications is in marriage counseling. On some of the "love myths" that obstruct our happiness, see Ellis (1985, pp. 33-37).

[267] See Ellis (1961, p. 106), Ellis and Bernard (1985, p. 20).

[268] Concerning the "tyranny of the shoulds," a phrase which Karen Horney coined, see, e.g., Rosenhan and Seligman (1984, 108-09).

[269] See, e.g., Stich (1982), (1983), and (1984). "The Case Against Belief" is the subtitle of Stich (1983).

assertion" to get across what the subject is thinking.[270] In my terms, we invoke our own notional world to understand others', and characterize their attitudes in terms of the properties we ourselves would believe in, if we were in (what we take to be) their place. A consequence of this method of attribution, however, is that it is limited in scope, as Stich (1984, p. 227) notes:

> If what we are doing in offering an intentional characterization of a person's cognitive state is identifying it by way of its similarity to a hypothetical state of our own, then we would expect that as subjects get less and less similar to us in salient respects, we increasingly loose [sic] our grip on how their cognitive states might be intentionally characterized. And there will be no comfortable intentional characterization for the cognitive states of subjects whose inference patterns are radically different from our own.

Of course, *any* practice has a limited domain, but according to Stich, by limiting psychology's application to just "me-and-my-friends" (as the Churchlands [1983] put it), we are settling for less than we should; in fact, Stich (1984, p. 230) charges, "there is a Protagorean parochialness built into the language of intentional description...[since] we ourselves are the measure of all things ...this is a positively perverse feature to build into a language in which we hope to do science."

As a more comprehensive replacement for intentional psychology without such an arbitrary range, Stich proposes the Syntactic Theory of the Mind, or STM. STM presupposes the Computational Theory of the Mind,[271] which sees cognition as the manipulation of sentence-like entities in the head according to formal rules; these structures are physical objects of sorts, and they can be described *syntactically*, i.e., according to their formal properties and relations.[272] Thus, to describe subjects' psychological profiles, Stich (1983) proposes that we start by observing their behavior, especially their verbal behavior, which should enable us to identify the "Belief-like" (B) or "Desire-like" (D) states underlying their assertions and actions, and then we simply formulate these states into well-formed formulae of a formalized language – but we do not have to *interpret* the content of cognitive states, we simply report their inferential or computational role in the subject, and generalize accordingly. For example, if we all made the inferences licensed by the *modus ponens* rule, a syntactic investigator would describe us thus: For all subjects S, and all wffs A and B, if

> S has a B-state mapped to A → B and
> if S comes to have a B-state mapped to A, then
> S will come to have a B-state mapped to B.[273]

According to Stich (1983, p. 158), it is a ***virtue*** of this approach that it eschews a semantic interpretation of subjects' cognitive states, since "by eliminating the appeal to various dimensions

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[270] See, e.g., Stich (1984, p. 227): "To say S believes that p, then, is to say that S is in a belief state similar to the one which would underlie my own assertion of 'p' were I (just now) to have uttered 'p' in earnest."

[271] Accordingly, STM might, Stich now (i.e., in his 1988 article, "Narrow Content Meets Fat Syntax") concedes, be superseded by connectionist approaches. Of course, connectionism may develop into an eliminativist theory, too, as Stich, Ramsey, and Garon (forthcoming) argue, but many of the same arguments presented here against the syntactic theory as a clinical practice will apply equally to connectionist approaches, assuming *they* ever develop to the point that they can seriously challenge intentional approaches.

[272] As Fodor (1981, p. 227) puts it, we can just talk about the "shapes" of the symbols.

[273] Stich (1983, p. 155); I have used "-- " in place of his horseshoe conditional.

of *similarity* [to the ascriber's own cognition,] much of the vagueness that plagues content-based cognitive theories is eliminated as well." Moreover, he contends that the syntactic theory should be preferred to the more parochial folk psychology, since it can offer generalizations applying to *all* cognitive systems – including those beyond the pale of intentional descriptions, a class which allegedly includes young children, "primitive" or "exotic" folk, and senile and brain-damaged people.[274]

As I've mentioned, I will be responding to Stich's allegations about the limitations of the intentional approach, but not until Chapter Five; this Section, however, will assess the theoretical and practical merits and shortcomings of his proposed alternative. According to what Stich sometimes calls his "Annie Oakley argument" (as in, "Anything you can do, I can do better than you!"), STM can do everything the intentional approach can, only better. E.g., in his (1983, p. 182), Stich summarizes his claims regarding STM's merits:

> The thrust of my argument throughout [his Chapter 8, on STM] has been that STM theories can do all the explanatory and predictive work of content-based theories, *and they can do it better*. For syntactic theories are not encumbered with the intrinsic vagueness and the built-in expressive limitations that plague Strong RTM theories.[275] ...Folk generalizations will coincide with STM generalizations in the theoretically uninteresting class of cases in which the subjects are similar to us. But folk generalizations will not extend to the mental states of young children, or primitive folk, or senile people, even when these people can be described by the same syntactic generalizations that apply to our own mental states.

It is interesting to note, however, that despite his being a theorist with such a pragmatic turn,[276] Stich does not mention *the ability to solve psychological problems* as part of the work that STM is better able to do. That omission in itself strongly suggests that Stich is proposing a very poor trade-off between STM's increased *descriptive* power (assuming he *is* right about that) and its decreased powers of *control*. In other words, in his bid to have a more universal and hence less parochial science by trying to formulate a stock of generalizations that can capture whatever cognitive principles we might have in common with those we (allegedly) can't understand in intentional terms, the syntactic theorist sacrifices the ability to deal satisfactorily with "the theoretically uninteresting class" comprised by those who *are* currently within the domain of intentional psychology – as I shall be arguing in section 4.3.3 below. Moreover, aside from being a very poor *applied* science, STM also provides weaker explanations for purposive behavior than intentional psychology does, and it isn't descriptively adequate, either, as I shall argue in section 4.3.2. But before we assess STM's limited powers of understanding and control, let's start by examining its *positive* merits.

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[274] See Stich (1983, pp. 8-9, 182).

[275] I.e., along the lines of Fodor's Representational Theory of the Mind; see Fodor (1981).

[276] E.g., see Chapter 5 of Stich's *Fragmentation of Reason*," where he addresses the question, "Why Should We Care If Our Beliefs Are True?" and he argues that inferential strategies should be preferred in accordance with how well they serve our interests and needs rather than for how well they accord with the normative canons of epistemologists and logicians.

The Positive Merits of STM: Schematic Generalizations

A substantial part of Stich's "Case Against Belief" is a series of examples in which we make predictions about behavior based not so much upon the content of our thought as upon the *way* we think; i.e., based on the inferential patterns we manifest. As an example, Stich (1983, pp. 130-41, 157) discusses the "belief perseverance" experiments of Ross *et al.*[277] which found that subjects in a psychology student subject pool tended to believe they had whatever personality characteristics or latent talents that a psychological authority tells them they possess (e.g., the capacity to distinguish genuine suicide notes from creative writing facsimiles) and they continue to believe it even after the same authorities discredit the putative evidence for what they were told. The point regarding STM is that it doesn't matter much *what* it is they're told, for as Stich (1983, p. 157) notes, we can predict that, when "given the questionnaire in the last part of the experiment, subjects commonly check the 'yes' box on the question" about their putative characteristics – without needing to know in any detail what their understandings of those characteristics *are*.

Clearly, many of the generalizations of psychology are thus syntactic – although "*schematic*" is probably a more appropriate term, since these are not *alternatives* to content generalizations, so much as they are generalizations *over* intentional content, as Stich himself notes (1983, pp. 157-58). After all, these are *beliefs* which are persevering, and beliefs have content. Let's grant, however, that there is merit to being able to describe psychological phenomena schematically, since they capture a wide variety of beliefs which may persist in such circumstances. But we want a psychological theory to do more than merely capture or describe generalizations; merely labelling or identifying the belief perseverance phenomenon only scratches the surface. The purely formal description that we do perseverate doesn't explain *why* we don't accept the "debriefing" (as Ross *et al.* call it). But part of psychology's mandate is to explain such phenomena.[278] Since Stich does not attempt to give a syntactic explanation of the phenomena, we must see whether we don't still need to appeal to content to understand it.

In this case, the question is, "Once we believe something – as when we're told it by an investigating authority – we tend not to let go even in the face of disconfirming evidence. Why not?" Although Ross *et al.* do not state outright that perseverance generalizations hold "in virtue of" the particular content of the beliefs held, that may very well be the correct *explanation* of the phenomenon which has been identified but not yet fully understood. Notice that in my somewhat loaded description of the experiments above, content *is* doing work even in describing the phenomenon: the prediction is that people will tend to perseverate upon beliefs induced by those they *perceive* as authorities. If the "doctor" conducting the experiment was known to the subject as some sort of comedian, the results would probably be quite different. Moreover, the fact that

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[277] See Ross, L., Lepper, M., and Hubbard, M. (1975). "Perseverance in Self-Perception and Social Perception: Biased Attributional Processes in the Debriefing Paradigm," *Journal of Personality and Social Psychology*, 32; or Nisbett and Ross (1980, pp. 175 ff.).

[278] Analogously, an electrical engineer might give a description of the *circuit* that tends to result in the display on a computer screen, but that would hardly explain *why* the display appeared; for that, you have to recognize that the computer was following its standing instructions to produce a graph of your expenditures to alert you of overdrafts. Nor would freeway shootings be explained by saying, "The shots are fired because nervous impulses are sent to the muscles in the hand holding the gun;" we are still left wanting to know the reasons *why* they shot, despite being told *how* they may have carried it off. I will return to STM's explanatory failings in the text.

our perception of legitimate authority plays a role in all of this may be crucial to understanding it, since the experiment presents subjects with a kind of liar's paradox.[279]

Nisbett and Ross (1980, p. 179) give an even more cognitive explanation, citing Bacon: "The evidence suggests that Bacon was correct in his assertion that 'the human understanding when it has once adopted an opinion draws all things to support and agree with it.'" Their explanation of the phenomena is that after being told about their newly discovered talents (or lack thereof), subjects develop a theory which draws on their life experiences to explain why they are the way the tests revealed; when the initial evidence is undermined after it is shown that the test results were cooked beforehand, they have enough alternative means of confirmation left to sustain the judgment.[280] Here is Nisbett and Ross's (1980, p. 192) summary of their discussion of the perseverance phenomena:

> Belief perseverance sometimes seems to occur because people have an emotional commitment to the belief. Perseverance is likely even when there is no such investment, however, because (a) people tend to seek out, recall, and interpret evidence in a manner that sustains beliefs, (b) they readily invent causal explanations of initial evidence in which they then place too much confidence, and (c) they act upon their beliefs in a way that makes them self-confirming.

The first thing they mention is the emotional factors that attach to the belief. These aren't *neutral* beliefs, because they are about our fundamental personality characteristics, whether it is being sensitive enough to distinguish genuine human pain from sophomoric attempts to simulate it (as in Ross *et al.*'s suicide-note example), or having latent homosexual tendencies (Stich's even more loaded example, in his [1983, pp. 133-34]). Our vanity is stroked when we're told that we're good at something, and we'll be understandably reluctant to give up our new-found talent and value; or, if we're told that we're bad at something, then our neurotic self-doubts will kick in to remind ourselves of other personal failings, and we're not going to let ourselves be cheered up so easily when someone tells us they were just kidding and we're really not so bad. If we were really so credulous about disconfirming evidence, psychotherapy wouldn't take nearly so long, but the fact is, we *resist* seeing the truth about ourselves, we *deny* many facts, and we *compartmentalize* others without fully appreciating their significance. Nisbett and Ross recognize this, as they indicate in their point (b) above: we are remarkably facile at generating (pseudo-)explanations for almost anything, including both natural phenomena (as *we* conceive of them – notionally), and our own behavior (which we try to make sense of in terms of reasons we may not have been conscious of at the time of acting).[281] Of course, our explanations are often not very penetrating, and often they are plain *wrong*, but the point is, folks do employ the resources of intentional or

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[279] Subjects in this experiment are presented with a curious kind of Liar's paradox – the doctor is an *admitted* liar (at least, he informs them that he intentionally deceived them); the question is, *which time*? when he seemed a legitimate authority and he told them how well they could recognize real suicide notes, or later, when he tries to convince them that he was just pulling their leg? Perseverance might just be due to our choosing to regard the later session as a curious *lapse* in the authority's character, an aberration from the proper routine, when he tells you *not* to believe what he has said. In other cases of conflict, however, when there isn't such a violation of our normal (and justified) expectations about the behavior of others, we are quite prepared to accept the updated information as the more reliable (e.g., when we receive a later statement or bill telling us to disregard the previous one that had an incorrect balance).

[280] Thanks to Michael Bishop (who studied with Richard Nisbett at Michigan) for discussion on this point.

[281] Nisbett and Ross (1980) also cite a number of studies documenting our facility at confabulating false reasons for why we *might* have done what we did, and also at spontaneously generating 'explanations' or causal attributions for why things happen in the world.

"folk" psychology in order to accommodate putative facts about the characteristics or behavior of people, ourselves included. Thus, when we are told that we are either well or poorly attuned to the minds of suicidal people, we look around for supporting evidence to square this with what we already knew about ourselves, such as how well we were doing in the psychology class (from which the subject pool was drawn), or how (in)sensitive we seemed to be to the feelings of depressed acquaintances, etc., and we'd find plenty of other reasons that are at least perceived to be relevant to the content of the attribute in question in our subsequent behavior (*cf.* Nisbett and Ross 1980, 180 ff.). It seems, then, that content *is* very relevant to understanding this phenomenon: subjects perseverate because they give a lot of thought to *what* they were told, they produce a *theory* which rationalizes why they should have this ability or tendency, and they select *relevant* evidence from both their past and their everyday life subsequent to the first part of the experiment to support the belief. If this is so, then syntactic or schematic generalizations need to be supplemented by intentional explanations in order to adequately understand the phenomena described by the former.

To sum up its positive merits, then: STM is true to its word in that it is able to "capture the generalization" about content-bearing states without needing to advert to the content directly. Thus, I agree with STM to this extent: we can describe such phenomena schematically, and there are hosts of other schematic generalizations in psychology (e.g., "People who want something and know how to bring it about tend to try to do so") where we don't have to specify what the "it" is (except with *ceteris paribus* clauses saying what 'it' is *not*: e.g., "unless it is someone's death"). However, STM does not *explain* such phenomena (whereas intentional psychology does), and thus it is incomplete. Moreover, STM hardly seems to be an *alternative* to intentional psychology by simply appropriating experimental psychology's schematic generalizations, which generalize over intentional states. But let's agree that syntax does do some work in psychology, and that many are still searching for the "laws of thought" such as Stich's *modus ponens* example cited at the beginning of this Section (although judging by the history of the endeavor it is unlikely that they will succeed.[282]

At any rate, the issue before us is *not* whether syntactic theories and generalizations *can* do work for us; it is whether there are some important things required of a replacement psychological theory that they *cannot* do, i.e., whether we also have need of "the notion of a contentful belief or memory." As I have been and shall be arguing throughout this dissertation, the answer is, "Yes – urgently," and thus, STM is unlikely to supplant intentional psychology. Granted that STM can accumulate a store of generalizations about cognitive systems' inferential patterns (insofar as any are forthcoming), then, let us turn now to examine the respects in which it is deficient in the traditional theoretical virtues of understanding and control, beginning with the former.

STM's Limited Explanatory Power

As an explanatory account, STM has, as Russell would say, "all the advantages of theft over honest toil" – it is merely parasitical upon semantic accounts. According to Stich (1984, p. 233),

[282] There are several reasons why we will probably never find laws or universal generalizations about the way we think: we probably do not cognize according to formal rules of inference (except in logic classes, and then not well); we are not the same; and as creatures in the world, our mentation is very subject to being set off course, both by things we ingest and by things that happen to us, so our cognition is probably quite variable and not law-like.

the STM theorist will label the syntactic states of subjects by *mentioning* the sentences they utter and noting their stimulus conditions, without attempting to translate what they mean. Thus, when an intentional psychologist would say a woman abandoned her baby because she believed that she would make a poor mother, a syntactic psychologist will say it was because "She had a belief-like state underlying her utterance of 'I am a poor mother'."[283] One suspects that the latter is merely a more stilted version of the former, but they are far from equivalent, as Stich himself is wont to point out.[284]

In fact, syntactic accounts of cognition tend to be far less informative, particularly when the subject does not speak the audience's language. Imagine our puzzlement when the syntactic investigator reports, "If the native assertion is 'Ga bu xiong', then the belief-like state in question is *the one expressed by 'Ga bu xiong'*" (see Stich 1984, p. 233). Since this literally amounts to giving meaningless reports regarding the *content* of the subjects' psychological states, we still don't understand *why* they are acting, i.e., what their *reasons* for behaving are. Even though we may be able to *predict* a subject's behavior if we are somehow provided with a sufficiently rich syntactic profile of the belief-like sentences constituting his cognition,[285] we won't *understand* the native's menacing behavior one jot until we realize that by "Ga bu xiong!" he means, e.g., "Stay away from these sacred burial grounds!"

But not only are syntactic reports singularly unenlightening when dealing with speakers of different languages, they also provide no appreciation of the motivations underlying human behavior. As Silvano Arieti (1968, p. 1637) puts it, in the chiefly conceptual type of thinking that distinguishes us from lower animals,

> ...the content is... much more important than the form....It is impossible to understand the human being without such important cognitive constructs as the self-image, self-esteem, self-identity, identification, hope, projection of the self into the future, etc. All these cognitive constructs are connected with or give origin to high-level emotions and consequently become an integral part of human motivation.

If the intentional psychologists are right, we really do act for reasons: we write papers because we want to convince people of our views; we run outside to roll up the car windows when we hear the weather report, because we think it's going to rain; and, as Arieti mentioned, many behaviors are due to our attempts to salvage self-esteem. But if we do act *because* we interpret what's going on, syntactic accounts – which omit reference to the content of the intentions underlying intentional behavior – are simply not going to provide adequate explanations for why we behave as we do.

It seems, then, that syntactic explanations don't provide an adequate understanding of human behavior, because they leave something very important out. This is a serious failing, because even apart from its practical limitations (which I'll soon be exploring in detail), it shows that

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[283] *Cf.* Stich's syntactic reconstruction of historical explanations: "To say 'Henry VIII believed that Pope Clement would allow the annulment' is to claim that Henry was in a belief-like state similar to the one that would underlie our own normal utterances of the content sentence." (1983, p. 227) I will return to this concession that there may be legitimacy to historical explanations later on, since it applies equally to clinical psychology.

[284] E.g., see Stich (1988).

[285] Below I shall argue that this is far from unproblematic, since an investigator who eschews interpretation is unlikely to secure the cooperation of his subject to elicit sufficient material to be able to map out a substantive syntactic profile.

STM isn't even descriptively adequate, since it lacks the resources to accommodate such phenomena as self-esteem, which are so crucial to psychopathology.

STM's Descriptive and Explanatory Limitations

To start with, I will explain why a syntactic approach which eschews interpretation or projective understanding won't really provide more *precise* reports of an individual's cognition, even though that's their aim, and then I will criticize its explanatory and descriptive power in general.

The Fidelity of Syntactic Reports

In contrast to intentional psychology's process of reporting on someone's cognition (which involves investigators in an implicit comparison between their subjects' ideas and experiences and their own), Stich (1983 p. 158) claims that the virtue of STM is that it "*eliminate[s] the middleman*" by avoiding characterizing mental states in terms of content sentences. Rather than taking liberties with a subject's speech with rough and ready translations that differ with the intrepeter and the audience as intentional psychology's interpretive accounts do, it would seem that syntactic explanations are more faithful, accurate, and "not encumbered with the intrinsic vagueness and the built-in expressive limitations that plague [the former]" (as Stich [1983, p. 182] puts it), since the syntactic psychologist only tells us what the subjects actually *said* (e.g., "Ga bu xiong!": see Stich 1984) before adding that there was some state or other underlying the utterance (which he shall simply call "B"). But is this right? ***Would*** an STM practice (if there ever were such a thing) really be able to produce more faithful or accurate attributions of cognitive states that could eliminate the vagueness and observer-relativity which beset content approaches? I shall argue that, despite appearances, the answer is probably "No."

The first thing to notice is that there is still a kind of interpretation involved in the central stages of the syntactic attribution, which involves distinguishing both types and tokens of the "B" states from the "D" states. The syntactic investigator must determine which utterances are expressions of "belief-like" states, and which ones indicate "desire-like" states, and which are commands, or exhortations, or requests, and so on, in order to effect his mapping from overt linguistic items onto the underlying cognitive states. But how is he to even begin this mapping *without* translating or interpreting to understand the nature of the subject's speech-act? These pragmatic considerations cannot be just swept under the rug.[286] *We* know whether the utter-ances issue from "the belief-box" or "the desire-box"[287] *because* we interpret them, but this avenue is not open to the syntactic psychologist, lest he import interpretation and vagueness into the attribution process. Moreover, not only do syntactic psychologists have to interpret the function and nature of the speech-act in order to type it as emanating from "B-states," "D-states," or whatever, but

[286] To be fair, Stich does mention the related problem of identifying mental tokens inside the subject in (1983, p. 152): "a subject may have more than one token of a given sentence type among his mental states. He may, for example, have one token of a sentence type which is a belief-like state and another which is a desire-like state...;" but he appears to take the issue of classifying the nature of the utterance for granted.

[287] See Stich (1983, Chapter 5, *passim*) which alludes to "B-states" which are stored in the mind's "Belief-box," an expository device he borrows from Schiffer (1981).

they also have to make decisions when classifying and re-identifying individual syntactic objects that are to appear in cognitive generalizations and explanations. Even as intentional psychologists who abstract away from the actual neurological states of a subject has to somehow distinguish whether she has the belief that ***p*** or the belief that ***q*** on the basis of her linguistic and non-linguistic behavior, syntactic psychologists mapping her spoken utterances onto postulated intermediate syntactic objects such as *sentence types* (if they adopt a sentential model such as Fodor's [1975]) have to decide whether they are dealing with an instance of a cognitive state of type B, or B', or B", etc. As Stich (1983, p. 152) states the issue,

> Since the motivation for viewing hypothetical neurological state tokens as sentence tokens is to describe causal relations by adverting to syntactic ones, we must ask just *which* syntactic relations must be mirrored for the neurological state tokens to count as sentence tokens.

To actually carry out this mapping, Stich (1983, p. 152) notes, theorists working within the STM mold have to adopt a ***holistic*** attribution process,[288] and their strategy is generally to insist, "only that to count as a token of some sentence type, a neurological state must satisfy some substantial number of the cluster of generalizations included in a theory, without specifying any particular generalizations that must be satisfied, nor exactly how many must be satisfied." It goes without saying that such holistic individuation procedures introduce elements of vagueness, and are likely to produce different results for different theorists.

The next and more pressing problem is that even if the syntactic approach is susceptible to *less* vagueness than the semantic approach in ideal cases, syntactic explanations will probably not go very far if they are the results of a purely syntactic methodology. Unless investigators employ the empathy Stich says they shouldn't, they probably won't even be able to get the data with which to map the postulated syntactic objects; i.e., they won't be able to elicit enough material to formulate a profile of the way their "belief-like sentences" interact, because the person will likely refuse to cooperate with someone who makes no attempt to understand what they are thinking or feeling. Faced with an insensitive investigator, people -- especially emotionally disturbed people -- are apt to say nothing much at all, or, worse, they are apt to either verbally or even physically attack their cold and clinical inquisitor.[289] Faced with such recalcitrance, the syntactic psychologist who finds he's not getting anywhere by doing straight empirical research (i.e., by simply observing and recording behavior) for want of data will probably soon find himself employing the same devices as the intentional psychologist: he will ascribe the "belief-like" sentences he might be thinking himself were he in the subject's place -- he will empathize with him or project his own understanding of how people think, as we do now. Consequently, any of the vagueness or loss of information attending attributions of content will be inherited by the ensuing syntactic explanations of behavior, if they, too, are working from reconstructed reasons; there would be no reduction in the vagueness if the syntactic psychologist were to blanch such explanations of content at the last stage by de-interpreting the ascribed sentences and translating

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[288] See Stich (1983, p. 153): "...no one neurological state can count as a token of a sentence type unless many neurological states count as tokens of many different sentence types."

[289] In lieu of attacking a bad interlocutor or investigator, patients may just mock him. E.g., see R.D. Laing's (1960, pp. 29-31) analysis of the text of the psychiatrist Emil Kraepelin, whose patient was satirizing the pompous doctor, who was too busy in exhibiting the subject to medical students and pronouncing him incomprehensible to notice the feelings of resentment over being so exhibited that the subject was expressing; it is reproduced in Chapter Five. I shall be returning to the importance of empathy in section 4.3.3 when considering STM's limitations as a potential clinical practice.

them into schematic belief-like sentences, for he has still *projected* those cognitive states, and thus the reports will still be interpreter relative, arbitrary, etc.

Thus, it seems the purely syntactic psychologist will either be left with ***no*** report of the subject's cognition at all because he won't have enough input-output sentences to work with (if he foregoes the resources of projective understanding to either facilitate communication with the subject, or else provide some of the cognitive material himself), or he will devise a report that is still plagued by vagueness and *ad hoc* assumptions.[290]

Is STM Even Descriptively Adequate?

As we saw, Stich (1983, p. 182) claims that "STM theories can do all the explanatory and predictive work of content-based theories, *and they can do it better*." In support of that claim, Stich (1983, p. 183) submits, "it has become increasingly clear that the most interesting and theoretically powerful generalizations are formal or syntactic ones which simply cannot be stated in the aboriginal language of content;" in other words, STM will be able to produce a greater stock of generalizations. However, I shall now be contesting the truth and significance of this claim that STM is more descriptively adequate than content-based theories.

To begin with, it is important to question the tacit presupposition here that it is the main business of science to stock-pile generalizations, much less purely formal ones. Stich seems to get this idea from Fodor,[291] but it seems to be a somewhat skewed or antiquated conception of the scientific enterprise, because even if it is *one* of science's primary tasks, it is surely not the only one, especially when considering *applied* sciences such as psychology. In applied sciences, more is not necessarily better – it depends on how *valuable* the generalizations are. An applied theory that can do more *work* with its smaller stock of generalizations is *prima facie* superior to a rival theory which either has more generalizations, or has generalizations that would apply to more cognitive systems (if there were any), if the latter cannot put (m)any of them to practical *use*.

The second point to make with regard to the putative descriptive superiority of STM is that it's not even clear that it *would* have more generalizations. It's far from apparent that there *are* any interesting generalizations to be found that apply to all cognitive systems. Given the very differences between the mental lives of ourselves and small children, senile people, stroke victims, and the like which Stich (1983, *passim*) draws attention to in support of his claim about the limits of the intentional approach, there may not *be* any important formal cognitive commonalities between us and them that we might make use of, anyway. Stich himself admits that we may need a different set of generalizations for children or others if their cognitive

[290] Indeed, Stich (1983, p. 156) seems to have actually already conceded something like this point, when he points out, "...an STM theorist may...advance generalizations that tie stimuli to B- and D-states or that link the latter to behavior. But commonly an STM theorist will not have nearly enough of these generalizations to put his theory to the test, at least not in the early days of theory construction. And for the foreseeable future, all days will be early days. So if theory is to confront data, the syntactic theorist will have to make a significant number of ad hoc assumptions about causal links between B- and D-states on the one hand, and stimuli and behavior on the other. These will be assumptions which the theorist takes to hold reliably enough in the experimental setting and for the subjects on whom the experiments are being run. It will generally be clear that these assumptions do not hold for other quite normal subjects."

[291] See Stich (1983, p. 128), quoting Fodor's Introduction to *Representations* (1981, pp. 25-26)

processes are significantly different,[292] so STM may very well not have anything over content theories, either in terms of the power of its generalizations, or the parsimony of its total of number generalizations. Indeed, there may not even be any important generalizations that hold up for "normal adult" human cognitive systems, much less across all cognizers. Surely, for example, even we 'normals' don't always infer in accordance with *modus ponens* whenever it's appropriate to do so, since we not only make mistakes, but we compartmentalize some beliefs, deny some facts we should know about, and so on; some inferences we *refuse* to draw, even when – sometimes especially when – they're staring us in the face.

But let's leave aside the question of how many broad, valid, and useful syntactic generalizations will be forthcoming, and concentrate on the claim that syntactic generalizations *can* do whatever the semantic ones can. Although Stich can certainly classify whatever syntactic generalizations there may be which apply across normals, children, the demented, and those with radically different beliefs as the "most interesting" ones, if he wishes, I submit that there are many instances of theoretically powerful generalizations that are stated in the "aboriginal" language of content which *can't* be replicated within the syntactic framework, so STM is descriptively inadequate.[293]

To see why this is so, we should take a brief excursion into the field of biology. As Philip Kitcher (1984) argues persuasively, it is not always the case that the categories of a higher level science can be reduced to a lower-level one; in particular, he argues that we cannot reduce the concept of a *gene* and the laws subsuming it to molecular biology, because although most genes are segments of DNA, we cannot, in molecular terms, say just which segments of DNA count as genes, since there will be exceptions.[294] Kitcher (1984, pp. 345-46) notes that the reductionist may attempt to forestall the objection by offering a disjunctive enumeration of all the *known* instances of genes described in molecular terms, but he counters that

> ...more than this is needed to reduce a *law* about gene transmission. We envisage laws as sustaining counterfactuals, as applying to examples that might have been but which did not actually arise. To reduce the law it is necessary to show how possible but nonactual genes would have satisfied it. Nor can we achieve the reductionist's goal by adding further disjuncts to the envisioned bridge principle. For although there are only finitely many *actual* genes, there are indefinitely many genes which *might* have arisen.

Just as the molecular biologist cannot reduce the fundamental genetic category of a *gene* and the generalizations into which it figures, so, too, I shall argue, is the syntactic psychologist unable to reduce some of the intentional categories and generalizations that are absolutely fundamental to the work of clinical psychologists.

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[292] See Stich (1983, p. 160): “To handle subjects whose basic cognitive processes differ from our own, the syntactic theorist may [need to (my addition)] specify a distinct set of *wffs* (a different "mental language") and a distinct set of generalizations exploiting the syntactic structure of these *wffs*.”

[293] This argument was suggested by Philip Kitcher, who leveled it at Stich, who was generous (and honest) enough to pass it on to me.

[294] See Kitcher (1984, p. 343). E.g., size is not an appropriate feature, since "Genes come in different sizes, and, for any given size, we can find segments of DNA that are not genes. Therefore genes cannot be identified as segments of DNA containing a particular number of nucleotide pairs."

Take, for example, the category of self-esteem, especially *negative* or *low* self-esteem. As we've seen, psychotherapy is literally a self-centered discipline, since the phenomenal self is at the center of its self-ascribed notional attitudes framework, and also since self-esteem has been identified as the factor most implicated in many psychological disturbances, such as depression and many neuroses. Let's remind ourselves what these involve, to see why syntactic accounts won't be able to accommodate them adequately. A phenomenal or representational self is both a body of representations (including beliefs such as "I am Canadian"), and an intentional agent (as Sandler and Rosenblatt [1962], for example, note): it is a self-modifying system. But since this is not the place to get into implementation issues, let's concentrate on self-esteem, which has to do with the quality of the representations and attitudes about the self. A fine illustration of notional world psychology which examines and explains the phenomenon of self-esteem is M. R. Jackson's (1984) *Self-Esteem and Meaning: A Life Historical Investigation*.[295] Illustrating his points with clinical material, Jackson shows us that self-esteem involves a number of factors, such as *ideology* (e.g., "People should be reliable"); *ideals* (e.g., "I want to be honest, like Abe Lincoln"); and *conflicts* (e.g., "How can I be both a good employee and a good husband?"). *Conflict*, as I mentioned in Chapter Three, is one of the most pervasive feature of the self's dynamic, and conflicts over beliefs, attitudes, and values[296] are often at the root of psychological difficulties, due to our efforts to maintain self-esteem. Self-esteem is so important to us, as Irving Sarnoff (1960, p. 255) notes here, that it sometimes outweighs even our instinct to survive:

> Generally speaking, the intensity of a motive is a function of the extent to which its reduction determines the survival of the organism. In the case of socialized human beings, however, motives concerned with the perpetuation of the self-concept generates a degree of tension which may be equal to, if not greater than, any of his motives which are related to his biological survival. And while motives pertinent to one's self-concept may be learned initially in the process of reducing the tension of survival-linked motives, they often seem to take precedence over the latter in the individual's response repertoire. Thus, a cursory glance at military history reveals, men will often knowingly give up their lives in the process of reducing the tension of motives induced by a challenge to their self-concepts.

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[295] Of course, Jackson doesn't actually call himself a notional world psychologist, but here in the conclusion to his work, Jackson (1984, pp. 206-207) draws on Kris ["The Personal Myth" (1956), in *The Selected Papers of Ernst Kris* (New Haven: Yale University Press, 1975).] to show a good way of understanding the processes of perceiving one's self and the character(s) of life, one which should sound familiar:

"Ernst Kris (1956) has described the construction of life history as the creation of a "personal myth." The individual weaves memory, fantasy, and current reality together to produce an autobiographical story extending from the past into the present and the future. Different people are assigned to play different roles, but always in relation to the self, which is the main character, protagonist, and hero of the story. Unlike the hero in an ordinary myth, however, the hero of the personal myth is the author as well as the central figure. He or she writes and rewrites the story at every moment of his or her life.

Becoming genuinely self-esteeming is probably something like becoming a good author. Interesting roles must be written for the characters, and certain literary forms must be observed. The self must not be given an easy dominance and a string of facile victories, for such a story is shallow and predictable. Nor can the self be accommodated to the roles of others, nor located in a system of trivial relations, for a confused and directionless plot will result.

...Self-esteem develops, then, as the personal myth is written and rewritten across the span of the individual's life. The story is refined, the characters are developed, the plot takes on new unity and meaning. And as author and product of its own transformation, the self moves toward reconciliation in the world of other people."

My thanks to Peter Mangan for bringing this book to both my attention and my mailbox.

[296] I'm not really going to make much of a distinction between beliefs, attitudes, and values, but for someone who does, see Rokeach (1968).

Clearly, then, self-esteem is important to our behavior, but can it be recognized within STM's purely formal or syntactic program which details cognition at a sentence-by-sentence level? The answer is "No," because these conflicts and attitudes about the self not aren't usually *formal* inconsistencies or outright contradictions, so much as they are clashes between values and apparent paradoxes which need to be interpreted in order to be recognized and resolved. As Jackson (1984, p. 111) puts it, "*meaning and conflict are deeply interrelated*;" because interpretation is needed to help someone realize that her life is riddled by a struggle between, e.g., wanting to be supportive and nurturing on the one hand, but not wanting to be as smothering as her own mother on the other, Jackson contends that we can't capture even the central facets of self-esteem in operational definitions or formal terms. Rather, self-esteem is a more holistic phenomenon which can only be understood in the process of a total interpretation of the subject's mental life.[297]

But even if the phenomenon of threatened self-esteem can't usually be recognized syntactically, can it at least be captured or described within the resources of the syntactic framework? Again, the answer is "No" – a syntactic reduction couldn't succeed, because there are simply too many ways to have attitudes about the self. This concerns not only self-esteem, but also a related diagnostic category: "ideas of reference," where subjects think "others are taking special notice of them, or saying vulgar things about them," e.g. (DSM-III 1980, p. 307). Many paranoid personalities and schizophrenics think people (and possibly radios, televisions, etc.) are always talking about *them* in particular, but they can instance these thoughts in an open-ended class of ways. The paranoid belief-like sentences in their heads might be using the words "me," "myself," "I," "numero uno," "the Chosen One," and on and on. Just as genes can be realized in a myriad of materials and forms, ideologies, ideals, and attitudes about the self can be realized in a potentially infinite number of ways – there are "billions and billions" (as Carl Sagan likes to say) of ways to think about yourself. Even if such attitudes can be identified individually by their function, the class as a whole cannot be reduced to a syntactic category, and thus the generalizations about the importance of self-esteem or ideas of reference in understanding and treating psychological disorders will be unavailable to it. Syntactic attempts to reconstruct these useful categories from the bottom up by brute force enumeration would be piecemeal and *ad hoc*, so we would do well to keep the higher level of description they would unsuccesfully attempt to copy.

Despite Stich's "Annie Oakley" claim, then, the descriptive and explanatory resources of STM can't do everything the conventional intentional theory can, because conventional wisdom contains a great deal of knowledge concerning how to deal effectively with people with low self-esteem, normal self-confidence, and even insufferable egoism, whereas these categories cannot be reconstructed by syntactic theories, which have no business in interpreting some cognitive states as being about the *self*, or in identifying some states as one's *cherished goals or ideals*, and so on. That brings us to an even more important virtue of scientific practices: the powers of control they provide. In particular, let's assess STM's ability to solve concrete psychological problems.

[297] Of course, Jackson's not alone in claiming that interpretation must be holistic; *cf.* Putnam (1983); or Stich (1983) for that matter, concerning both semantic (p. 54) and syntactic attributions (p. 153).

STM's Problem-Solving Ability

I shall now gauge whether the syntactic psychologist *qua* syntactic psychologist is likely to be able to help us with our problems in living, and argue that it is highly unlikely that he can. In a word, the reason is ***empathy***, the "cognitive awareness and understanding of the emotions and feelings of another person" (Reber 1985, p. 238). As the first step in support of the conclusion that psychology in clinical practice cannot be purely syntactic, I shall argue that even if the syntactic clinical psychologist were able to devise some non-interpretive means of treating patients or clients, he cannot do his job unless he avails himself of semantic categories which presuppose the use of empathy with which to *diagnose* psychological disorders, given how they are currently conceived. Next, I shall argue that a would-be syntactic psychotherapist who avoided employing empathy would probably encounter very poor results in clinical practice.

Diagnosis and Semantic Categories

As I mentioned in Chapter Three, whether we like it or not, diagnosis is part of the clinical task; diagnostic categories may not be used reliably or even well, but they must be used, since clinicians have to call the conditions *something* when they submit their bills to governmental and insurance agencies, and when they are called upon to make professional judgments about diminished responsibility. As it stands, however, psychological disorders and disturbances are judged according to semantic criteria, and they probably always will be, as long as we are concerned with the crazy notions people sometimes get.

Of course, not *all* of psychiatry's diagnostic categories appeal to the content of subjects' psychological states: some refer to loss of affect, or appetite, or to irritability. But clearly a significant percentage of them *do* identify psychological problems at the semantic level, in terms of such constitutive symptoms as "irrational" fears or phobias;[298] the "pervasive and unwarranted suspiciousness and... hypersensitivity" which is typical of paranoid personalities (DSM-III 1980, p. 307); the "bizarre" or "incoherent" speech of schizophrenics or schizotypal personalities;[299] and even an inability to grasp "the big picture," which is characteristic of compulsives.[300] These and a variety of other psychological phenomena necessitate interpretive judgments on the part of the investigator about the match-up between the subject's behavior or perception of the world and that of the public at large; e.g., to judge whether someone's speech is "incoherent," obviously, we must interpret his speech as best we can.

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[298] See DSM-III (1980, p. 225): "*PHOBIC DISORDERS (OR PHOBIC NEUROSES)* The essential feature is persistent and irrational fear of a specific object, activity, or situation that results in a compelling desire to avoid the dreaded object, activity, or situation (the phobic stimulus). The fear is recognized by the individual as excessive or unreasonable in proportion to the actual dangerousness of the object, activity, or situation."

[299] Concerning the odd speech of the schizotypal personality, see Chapter Three, or the DSM-III (1980, pp. 312-313), or George Valiant and J. Christopher Perry, "Personality Disorders," in Kaplan and Sadock (1985, p. 972). I will be discussing schizophrenic speech again in Chapter Six.

[300] Concerning the Compulsive Personality Disorder, the DSM-III (1980, p. 326) notes, "The essential thing is a Personality Disorder in which there generally are restricted ability to express warm and tender emotions; perfectionism that interferes with the ability to grasp "the big picture": insistence that others submit to his or her way of doing things; excessive devotion to work and productivity to the exclusion of pleasure; and indecisiveness."

To see this point illustrated in more detail, consider ***delusions***, which afflict psychotics. To begin with, the entire class of psychoses is defined according to whether the subject 'knows what's going on': e.g., the DSM-III's (1980, p. 367) glossary defines "Psychotic" as "A term indicating gross impairment of reality testing...the individual incorrectly evaluates the accuracy of his or her perceptions and thoughts and makes incorrect inferences about external reality, even in the face of contrary evidence." Direct evidence for this, the DSM-III (pp. 367-68) notes, "is the presence of either delusions or hallucinations without insight into their pathological nature." Delusions themselves are "false personal belief[s] based on incorrect inference[s] about external reality and firmly sustained in spite of what almost everyone else believes and in spite of what constitutes incontrovertible and obvious proof or evidence to the contrary,"[301] while "delusions of grandeur" involve inflated opinions of one's self.[302] Such explicit appeals to the truth or falsity and apparent irrationality of psychotics' attitudes obviously involves investigators in semantic judgments, and requires them to both interpret the content of the subjects' attitudes and assess their justification or warrant by comparing them to those of the surrounding culture's.[303]

Consequently, so long as we are interested in knowing whether or not people are psychotic, interpretation cannot be eliminated in the applied science of psychology, and thus even a would-be syntactic psychotherapist would have to engage in *Verstehen* or interpretive understanding, as well, in order to properly do his or her job. Since these interpretive judgments are *not* the levels that the syntactic theory trades in, STM is therefore deficient and won't be able to eliminate intentional psychology.

In response, an advocate of the syntactic approach can always reply that some day we may cease to judge madness according to such categories as whether people are rational or make sense. However, since that's certainly how we do it now, and since it seems quite appropriate to do so (given that people do act on their crazy ideas and irrational fears, and their actions can affect the rest of us) the burden of proof is definitely on the syntactic psychologist who would replace or eliminate such categories to say why we should think things ever will or should change. And if these semantically-charged categories *don't* change, then even a syntactic clinician will need to engage in interpretation, at least to know when to begin and end treatment, if not in-between as well. This much said about diagnosis, I shall now explain why empathy is important for the subsequent stages of effective therapy, too.

The Role of Empathy in Facilitating Change

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[301] DSM-III (1980, p. 356), which hastens to add that delusions are to be distinguished from more widely shared dogmas: "...The belief is not one ordinarily accepted by other members of the person's culture or subculture (i.e., it is not an article of religious faith)."

[302] E.g., the DSM-III (1980, p. 359) defines "**Grandiosity**" as "An inflated appraisal of one's worth, power, knowledge, importance, or identity. When extreme, grandiosity may be of delusional proportions. Example: A professor who frequently puts his students to sleep with his boring lectures is convinced that he is one of the more dynamic and exciting teachers at the university."

[303] Once again, the DSM-III (1980, p. 367) hastens to note that such judgments are a matter of (extreme) degree: "The term psychotic does not apply to minor distortions of reality that involve matters of relative judgment. For example, a depressed person who underestimates his achievements would not be described as psychotic, whereas one who believed he had caused a natural catastrophe would be so described." Clearly, however, this involves interpreting the content of the aberrant beliefs.

Because empathy or projective understanding – the very thing that STM eschews and regards as unsuitable to the needs of a respectable science – is the *sina qua non* of successful psychotherapy, a purely syntactic or non-intentional therapy would probably be disastrous in the treatment of most psychological disorders. Apart from extremely simple cases of phobias (which I shall discuss in due course, and to a considerable extent even then, as I shall argue), we're simply *not* going to be helped by clinicians who don't try to understand our inner selves, choosing to regard us instead as defective computational devices with aberrant syntactic objects which need to be scrutinized and reprogrammed.

Short of, say, *marrying* us, or giving us money or a better job, therapists can help us feel better about ourselves and resolve our personal problems only if we entrust our innermost thoughts to them. But – except for narcissistic personalities (who like to talk about themselves, whether or not anyone is listening) – we're simply not going to do this when the therapists don't care to understand them. This seems to simply be a "*brute fact*" about people – we don't respond well when we are treated like objects[304] – but in support of this claim about the indispensability of empathy, I shall first cite some relevant experimental evidence, and then explain in more detail *why* projective understanding is so crucial when dealing with people and their problems.

We saw above that Rogers claims accurate empathy, positive regard, and congruence are necessary and sufficient conditions for therapeutic success. That ambitious claim has certainly been contested,[305] and it is probably foolhardy to claim that *any* technique will work for ***everybody***, given how different we can be. However, it *is* reasonable to submit that empathy *is* a necessary ingredient of successful psychotherapy in the vast majority of cases, given the experimental studies performed by Truax and Carkhuff *et al.*(who pursue Rogers' approach), which Matarazzo summarizes here:

> The client-centered group has published a number of research studies suggesting that high therapist conditions in individual psychotherapy [accurate empathy, etc.] ...are associated with constructive patient change, and that the absence of these conditions can lead to deterioration in patient functioning....Truax and Carkhuff (1967) reviewed much of this early work. Bergin (1963) also related that low empathy is related to client deterioration. Truax, Silber, and Carkhuff (1966) reported a beneficial effect of therapist empathy in therapy groups. Bergin and Solomon (1970) found that psychology graduate students' empathy in psychotherapy interviews was related to their general therapeutic competence, as judged by supervisors.[306]

These and other studies show that when the therapists are rated as being *low* in empathy skills, they tend to have poor results. As Rosenhan and Seligman (1984, p. 629) put it,

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[304] See Rogers (1961, *passim*; or Rogers' "Persons or Science? A Philosophical Question" (*American Psychologist* 10, 1955: 267-78), cited in Karasu (1977).

[305] E.g., Ruth Matarazzo, "Research on the Teaching and Learning of Psychotherapeutic Skills," in Bergin and Garfield (1978) contests the claim that Rogers' triad of therapist's qualities is *sufficient* for change.

[306] Matarazzo (1978 [see last note], p. 944); she is referring to C.B. Truax and R.R. Carkhuff (1967), *Toward Effective Counseling and Psychotherapy: Training and Practice* (Chicago: Aldine); A.E. Bergin (1963), "The Effects of Psychotherapy: Negative Results Revisited," *Journal of Counseling Psychology*, 10, 244-50; Truax and Carkhuff with L.D. Siber (1966), "Accurate Empathy, Nonpossessive Warmth, Genuineness and Therapeutic Outcome in Lay Group Counseling (unpublished manuscript, University of Arkansas); and Bergin and S. Solomon (1970), "Personality and Performance Correlates of Empathic Understanding in Psychotherapy," in T. Tomlinson and J. Hart (eds.), *New Directions in Client-Centered Therapy* (Boston: Houghton-Mifflin).

> It is generally believed that warmth, empathy, and genuiness are necessary preconditions for successful therapy, though they do not guarantee it (Gurman, 1977; Mitchell, Bozarth, and Krauft, 1977). These characteristics would seem to apply to all kinds of therapists, regardless of their orientation. For example, with regard to behavior therapy (which concentrates more on changing immediate behavior rather than the exploration of feelings), Marks and Gelder (1966) have argued that the single most important ingredient in determining outcome is the relationship between client and therapist.[307]

Clearly, then, there are experimental studies supporting the claim that accurate empathy is a prerequisite for successful psychotherapy.

However, I don't want to spend a lot of time marshaling evidence to show *that* empathy is important, for I shall explain now *why* it is so important, and why folk psychology is here to stay (at least, why it *better* be). Stich (in conversation), submits at least for the sake of argument that we don't need *Verstehen* or projective understanding of content-laden states to treat someone successfully, any more than we need to know how a car feels inside to know how to fix it. However, although it's true that *Verstehen* isn't needed to fix cars, because cars don't *have* feelings (if they did have a mental life, they'd be even more troublesome), it's *not* true for us, for several reasons. For one thing, we're *not* cars, and we often plain *refuse* to get better if you treat us as though we were. Moreover, our psychological problems *are* meaningful problems (in fact, one of the biggest problems people have is with "the meaning of life"!), but by his very nature, a syntactic psychologist is disqualified from dealing with such problems at that level. And at the very least, the psychologist cannot even *discover* what our problem is unless he attempts to use empathy to communicate with us and translate what we say; allow me to explain why.

To see the point, we should try to imagine what it would be like to deal with people without making an attempt to understand them. Even the therapists rated as having poor empathy skills in the studies cited above probably had a lot more empathy than a *bona fide* syntactic psychologist would have, since they were at least speaking more or less the same language as their clients, and so probably interpreted at least most of the *surface* content of what they were saying correctly, even if they didn't pick up on the more personal resonances. The syntactic psychologist, on the other hand, holds that there is no place for *Verstehen* in his science ***at all***. That would be like John Searle's infamous (1980) "Chinese Room" thought-experiment, which also has us imagine that we could converse with someone without knowing what he said, by manipulating strictly formal and syntactic rules.[308] In such a situation (where a monolingual American locked in a room with a codebook passes Chinese messages back and forth to a Chinese speaker outside) perhaps the syntactic psychologist would be able to provide his interlocutors with a pleasant enough 'conversation' if the subject matter is banal enough, but can he help them with their difficulties without knowing what on Earth they were saying? Not if they need to go into any depths, I would submit, because they will recognize how facile the responses are, and break off

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[307] Rosenhan and Seligman are referring to A.S. Gurman (1977), "Therapist and Patient Factors Influencing the Patient's Perception of Facilitative Therapeutic Conditions" (*Psychiatry*, 40, 218-31); K.M. Mitchell, J.D. Bozarth & C.C. Krauf, "A Reappraisal of the Therapeutic Effectiveness of Accurate Empathy, Non-Possessive Warmth, and Genuineness" (in A.S. Gurman & A.M. Razin, Eds., *Effective Psychotherapy: A Handbook of Research*, New York: Pergamon, 1977); and I.M. Marks, & M.G. Gelder, "Common Ground Between Behavior Therapy and Psychodynamic Methods" (*British Journal of Medical Psychology*, 39, 1966, 11-23). I will be returning to the importance of empathy even in behavioral therapy in Section 4.3.3.4 below.

[308] See Searle (1980), "Minds, Brains, and Programs."

the conversation. Moreover, Searle was of course merely granting for the sake of argument that all the formal relations had *already* been mapped out and that you could thus determine which responses are appropriate in advance, but we don't have anything like this luxury when dealing with the people who somehow wind up in our psychologists' offices and psychiatric institutions, whose cognitive and linguistic patterns are an unknown commodity. Furthermore, in order to 'can' the appropriate responses, the programmer would probably have to trade on his knowledge of the language's semantic relations, in order to know what meaningful responses *to* make.

However, it might be objected that a computational therapy that can mimic the effects of a Rogerian therapist already exists in the form of Joseph Weizenbaum's ELIZA program, that wonderful parody of both AI and psychotherapy which responds by simple manipulations of the incoming sentences.[309] However, although some people may benefit from pouring out their troubles to a machine, even as some do by writing letters to themselves or by talking to their pets, in general we won't get the same results from "talking to a brick wall" as we would from communicating with a real person. Most people (again, except for extremely narcissistic ones) quickly get bored by ELIZA's turning their phrases back at them, and it has very little therapeutic value. Even non-directive therapies aren't like ELIZA, because in the process of "reflection of feelings" which is so central to it, you don't actually repeat the subject's same words according to set patterns – instead, you convey their content back to them using your own terms, which requires you to interpret and understand what they say.[310] ELIZA, on the other hand, clearly doesn't understand anything we say, which is why working with it is often a far more frustrating experience than it is beneficial, as you'll discover as soon as you try to *insult* it. Let's leave computers, then, and return to human relationships.

My first contention is that, except for extremely simple cases (e.g., a fear of snakes), an investigator cannot even *identify* the client's problem without using empathy, much less treat it. Quite simply, the problem is that a syntactic investigator is unlikely to be able to generate enough material to work with, for the reasons I've already mentioned. Although Stich (e.g., 1984) likens psychology to anthropology as Quine sometimes does,[311] and writes as though the investigator is simply *given* the subject's functional role profile (which includes what sentences he will utter in what circumstances), this is not a realistic picture of what goes on in clinical settings. Clinical psychology is quite unlike the ideal cases of fieldwork in anthropology in which the natives carry on as usual and continue to say many things, despite the presence of investigators. In clinical practice, the subject's thoughts must be *sought* in a co-operative, "me-and-my-friend" relationship, since we *don't* have films of all our relevant behavior for third parties to peruse, nor are we likely to permit such wide-scale surveillance. But without sufficient material to indicate how the subject is cognizing, the syntactic psychologist won't even be able to make an intelligent diagnosis or plan of treatment, much less be able to carry it out, unless he converses with them and demonstrates that he understands what they are telling him.

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[309] For an account of ELIZA, see, e.g., Bertram Raphael, *The Thinking Computer: Mind Inside Matter* (San Francisco: Freeman, 1976).

[310] On "reflection of feeling," an important part of the therapeutic process, see, e.g., Bernstein and Neitzel (1987, p. 299).

[311] E.g., see Quine (1960), or "Ontological Relativity," in *Ontological Relativity and Other Essays* (New York: Columbia University Press, 1969).

Of course, it may be *possible* to devise some alternative means of getting to know someone via some parapsychological "mind-reading" techniques,[312] but given all that we know about people and brains, it surely seems *highly* unlikely that we can discover much about someone's thoughts and feelings except by *asking* him, and hoping that he trusts and admires us enough to tell us. However, he's not going to do so if we pay no attention to what he is thinking and we don't bother to interpret the significance of what he says. Patients barely tolerate the clinical eliciting of personal information by medical doctors searching for the presence of symptoms to identify a disease,[313] but they do not respond well at all to such cold probes into their inner feelings. We're just not going to cooperate if we don't feel we're being treated with respect, and we won't, if the therapist doesn't attempt to understand what we're saying. If the interviewer just keeps saying, "Tell me more," or "More input!" the interviewees will soon cease to have respect for him, too, and they'll leave, or, if they're institutionalized, they'll clam up or become abusive. Bear in mind that the things they most need to talk about are the sensitive areas that they are generally *least* inclined to talk about, since they provoke such anxiety. To help them cope with this anxiety over such topics as homosexual feelings and decrease their resistance to talking about the sensitive topic, you have to show them that you know what they're worried about, and you also know it is something that can be dealt with.[314]

If half of what I've been saying about the importance of self-esteem in the development of neuroses is true, then it should be clear that it is of paramount importance that we must respect the subject's autonomy in the interview process. Without engaging in projective understanding and then demonstrating to their clients that they do "know where they are coming from," a therapist probably cannot facilitate growth or change in their personalities, except for extremely simple problems. We have just seen the first reason why – understanding is needed to elicit information from the subjects about their views – but now let's proceed to a second reason: it is also needed to persuade them to change them.

The Art of Persuasion

Suppose for the sake of argument that syntactic psychologists are somehow able to overcome people's reluctance to discuss personal problems with those who don't make a sincere attempt to understand them, and suppose further that they are able to obtain sufficient data to map a substantial functional profile of their subjects' cognitive states (as they would if they had videotapes of the person's entire life), including the crucial underlying belief-like sentences that embody their insecurities or feelings of worthlessness. The question is, will a syntactic psychologist be able to extirpate these harmful cognitive states and replace them with more adaptive ones without knowing what they mean, and without using projective understanding?

A good psychotherapist *listens* to what subjects say, recognizing that it's not meaningless gibberish. ***Bad*** psychologists *don't* listen, which only succeeds in making their "patients" feel more alienated and miserable. If the syntactic psychologist's advice is to do the latter, we mustn't

[312] For example, the telepathic "Vulcan mind-meld," employed by *Star Trek*'s Mr. Spock; this is not, unfortunately, within human capabilities. Meanwhile, back on Earth (as Woody Allen says in *Annie Hall*), we have pressing needs and should not let appeals to outlandish science fiction influence our evaluation of a needed discipline in the here and now.

[313] E.g., such delicate questions such as, "Regular bowel movements?"

[314] See Sullivan (1954, p. 215).

follow it, if we are to be of help. Psychologists who don't listen, i.e., actively interpret what subjects are saying, are likely to get nowhere, and it will soon become obvious to both parties that they're not making contact. Of course, that happens, even with the best therapists, and particularly in the first stages of the therapeutic relationship,[315] but when it persists, the beneficial results are likely to be quite limited.

Once contact is established using empathy, however, the therapist may be able to convince the clients that the defense mechanisms they have employed (of dissociating elements of their personality, e.g.) are not working, or that changes can be made in their unhappy family situation, and so on. But the therapist cannot successfully communicate optimism about the prognosis, which is widely acknowledged to be critical to most healing processes, unless he knows what the subject finds disturbing. One might suppose that one only has to give the *appearance* of warm understanding to activate the so-called "placebo effect," that one can reassure subjects and make them feel better without really knowing what they are talking about. However, one can't just offer a lot of false reassurance and expect to get good results. As Sullivan (1954, p. 216) succinctly puts it,

> The point is there is no use trying to reassure a young adolescent – or anyone else – if you don't know what you are reassuring him about. And you ordinarily don't know what to reassure him about, aside from a few good bets such as masturbation used to be – and even in that case, you still had to be told about it before you could do anything about it. You cannot do magic with reassuring language.] On the other hand, clinicians generally find that therapeutic progress is made as soon as the subject recognizes that his empathetic therapist does understand how he feels, after they have been ignored and misunderstood by their family for so long.[316]

Important as they are, discovering the problem and communicating optimism for being able to deal with it are not enough – empathy is needed to do more work than that. To get the profound changes required, therapists can't just get clients to chant the words "I'm okay, you're okay!" or simply get them to *say* they don't blame themselves for their childhood 'seductions' – they have to ***mean*** it. The changes have to be significant, in both senses; the new 'belief-sentences' we're trying to get them to self-ascribe must *have* content if they are to be of any effect, and they must resonate with personal significance and conviction. The question is, ***how*** can this be accomplished – how can we get someone to adopt a healthier set of attitudes about themselves and the world?

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[315] E.g. Sullivan (1954, p. 118) notes, "Early in a relationship, the interviewer may know what *he* said and what *the patient* said, but nevertheless it was if two strangers were talking to themselves," but adds, "Later interviews often progress to what amounts to singularly subtle communications of fact."

[316] E.g., see Laing (1960, p. 35). Gordon (1975, p. 80) also gives powerful examples of the cathartic benefits of active listening in parenting, with the moral being, "The lesson for parents...is *to accept* the way your child feels rather than try the direct approach of *trying to get rid of* the whining and pestering by reassurance or threats. *Kids want to know that you know how badly they feel*." Gordon (1975, pp. 229-30) gives a particularly graphic instance of the effectiveness of empathy or active listening which concerns a two year old's tantrum, as described by the mother:

"I was cooking dinner one night and my daughter was gurgling happily on her rocking horse. Then she took the straps used to buckle the child on and began to try to buckle the straps herself. Her face reddened and she began to scream in a high-pitched voice as her frustration mounted. I found myself getting angry at her screaming, so in my usual fashion I knelt down to do it for her. But she fought me and kept screaming. Now I was ready to pick up her and the rocking horse and deposit them both in her room, slamming the door to shut out the noise. Then something clicked in me. So I knelt down, placed my hands on top of hers and said, 'You're really mad because you can't do that yourself.' She shook her head, 'Yes,' stopped the screaming, and a few belated sobs later was again happily rocking away."

Of course, active listening doesn't always bring miracle cures quite so easily, but it's often a necessary first step.

As I attempted to show in the previous Section, there are many things going on in therapy, such as demonstrating to subjects that they are of some worth via the quality of the therapist's concern, and getting them to assimilate a healthier set of values. But one of the important processes in psychotherapy, as Frank (1961) points out in his *Persuasion and Healing*, for example, is *persuasion* – the therapist has to attempt to *convince* clients through various means that they are not so terrible as they may think, and that they are capable of turning their lives around. This is why "Come, let us reason together!" serves as the rallying cry for many therapists, and why many others (e.g., Beck and Ellis, as we'll see in Chapter Seven) invoke the name of Socrates while explaining their craft. Even Freud once wrote that psychoanalysis is a process of "talking people into and out of things."[317] The philosophers among you may recognize this process as one you engage in yourselves: rhetoric.

Despite its connotations, rhetoric isn't necessarily a bad thing, where a speaker manipulates his audience in order to consolidate his own power base; as Szasz (1978, pp. 20-21) notes, there can also be *good* rhetoric, when the therapist uses her powers of persuasion to bring insight to clients convince them of the wisdom of taking up better ways. But how does rhetoric work? It turns out that ***empathy*** is irrevocably bound up in the process, because if you are to persuade someone of something, you must represent yourself as sharing their interests, which requires you to know what those interests are, and to do that you must assume their point of view in order to come to common ground, as Brooks and Warren (1970) explain in their *Modern Rhetoric*:

> In persuasion...the persuader earnestly seeks to eliminate conflict from the germ situation, and if doubt exists he maintains that it must be shared and resolved in a joint effort marked by mutual good will. The persuader's characteristic assertion is that any difference between his point of view and that of the persuadee is the result of only a slight misunderstanding that can readily be cleared up by a little friendly discussion, for they are two persons of essentially identical interests.
>
> In other words, what the persuader seeks is the broadest possible common ground with the persuadee....As the eminent critic Kenneth Burke has put it in *A Grammar of Motives*: "You persuade a man only in so far as you can talk his language by speech, gesture, tonality, order, image, attitude, idea, *identifying* your ways with his." *Identification*, not conflict, is what the persuader seeks.
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> ...Clearly the persuader cannot achieve identification or exploit the persuader's relation to a group unless he knows the audience...[e.g.] Abraham Lincoln, in his famous debates with Stephen A. Douglas in 1858, altered his pronouncements about slavery according to the latitude of Illinois in which he was speaking.
>
> ...Persuasion begins...with the persuader's act of identification and ends with the persuadee's act of assent, and both of these are psychological rather than logical events. That is, they involve the total man, not merely the mind working objectively and logically. The act of identification involves, as fully as possible, all the extralogical aspects of the persuader: he must, as Kenneth Burke puts it, take on all the "ways" of the persuadee. ...though by identification the persuader apparently surrenders his will to the persuadee, in the process he actually seizes the will of the persuadee...he lulls it, bemuses it, beguiles it, and he does so by appealing to the desires of the persuadee. (pp. 240, 241, 242, 245)

To persuade someone, then, we need to understand what they already think, and build on that in order to convince them of something else; that's how rhetoric and education work – by employing empathy and using our cognition to produce changes in their's. Moreover, persuaders change their audiences' views through a variety of meaningful devices: to truly bring the point

[317] Freud described psychoanalysis this way in a letter to Fleiss, which is quoted in Szasz (1978, p. 109).

home, they make the same point in many different ways; exploit synonymy relations; offer supporting arguments; make analogies to things their audience does accept; offer appealing or instructive metaphors;[318] and so on. However, the importance of just these sorts of semantic relations is both denied by the syntactic approach and denied to it, making it an inappropriate candidate to replace the intentional paradigm.

Granted, a syntactic therapist can *try* to achieve the same results as persuasion does through different means than adopting the audience's viewpoint and convincing them that you have the same interests in order to get them to adopt your views, but the question is, *how* can or will he do it without *Verstehen*? The tried and true method of doing so employs empathy, and it seems unlikely that we shall find a superior alternative; arguably, the *only* or the best way to bring significant, lasting, and beneficial change is via a therapeutic relationship that employs projective understanding. However, that claim *needs* argument, since even if STM is not up to the task, there may be some alternative means of treatment that is, which doesn't need to rely upon interpretive understanding. Accordingly, in Chapter Seven, I will argue that somatic psychiatry, psychotherapy's main rival, is unlikely to be able to eliminate the services of intentional psychology; but first, in the balance of this Section, I shall consider a practical alternative a syntactic approach might endorse as a logical extension of itself.

Alternative Methods of Control: Behavioral Therapy

The syntactic psychologist may be willing to grant that his own approach may pale beside that of a "talk" therapist when it comes to dealing with the psychologically disturbed, but he can perfectly well reply that the content-based approach may be eliminated, nonetheless, so long as he is able to subcontract these duties to some alternative discipline compatible with his own approach. The only available candidate which seems suitable to the task, however, would seem to be behavioral therapy, the one major school of psychotherapy that doesn't seem to employ content. Judging from their name, at least, one might legitimately suppose that ***behavioral*** therapies represent the clinical branch of Behaviorism, a paradigm which shares STM's disdain for *Verstehen*. It would thus seem that there is already a potentially effective eliminativist clinical alternative to intentional psychology up and running, despite my claims about the importance of empathy for treatment. Indeed, some of its influential advocates such as H. J. Eysenck have argued that behavioral therapy is not only an alternative to interpretive psychotherapy, but also a vastly superior one.[319] Worse still is the fact that Cognitive Therapy –

[318] E.g., Lenrow (1966, p. 145) notes that Butler *et al.* suggest that the wide range of connotations suggested by metaphors such as "You're dragging your heels" or "coming out of your shell" "stimulates the greatest variety of associations in the client and thus helps make available the greatest variety of experiences from which the client may create new thoughts or interpretations of his behavior." (See J. Butler, Laura N. Rice, and Alice K. Wagstaff, "On the Naturalistic Definition of Variables: An Analogue of Clinical Analysis," in H.H. Strupp and L. Luborsky, eds., *Research in Psychotherapy*. Washington, American Psychological Association, 1963, 178-205.) Lenrow goes on to discuss other functions of metaphors, besides getting to see clients to see themselves in a new way by non-intrusive and even somewhat playful means, such as their ability to convey in concrete terms how the client relates to others.

[319] In his interview with Evans (1976, p. 256), Eysenck says his critique "applies to all psychotherapies that are currently in use. They all fail to give proof that they work better than no therapy at all. And until you get that proof, the whole movement is unscientific." However, he especially targets psychoanalysis; e.g., he goes on to say that Freud "really has been a great misfortune to the development of scientific psychology and scientific psychiatry. He set us back about 50 years." Although I fault Freud the man and the practitioner (for reasons I explain in Appendix A), I find Eysenck's judgment far too harsh. As I'll explain in Chapter Six, Freud's theoretical contributions, (including such notions as

which I shall defending against more neurobiologically inclined eliminativists in Chapter Seven as one of the best therapies of mental "illnesses" we are likely to get – is listed in textbooks such as *Introduction to Clinical Psychology* as a species of behavior therapy![320] Let's see what these challenges portend for notional world psychology, if anything.

As we are about to see, on various sorts of analysis, behavioral therapies are not that different from cognitive ones, which suggests that there's not such a sharp difference between behaviorism and cognitivism, after all. However, since that can cut both ways (since it can be challenged that cognitive therapy is effective but merely behavioristic,[321] in what follows I shall be paying particularly close attention to the role played by content and empathy even in the so-called behavioral therapies, and arguing that to the extent that behavioral therapists are on the right track, they are actually practicing a form of content-based psychotherapy, but to the extent that their practices and views diverge from the notional world framework, they are inadequate and mistaken.

Let's start by getting an idea what behavioral modification therapies are: a few basic techniques designed to get people to unlearn maladaptive responses, and learn better ones. For example, the behavioral treatment of a typical obsessive/compulsive disorder might consist of a combination of the three basic techniques, as Rosenhan and Seligman (1984, p. 246) explain: response prevention; flooding; and modeling; which

> ...encourage and persuade but do not force the patient to endure the disturbing situations that set off obsessions, without engaging in compulsive rituals to undo the thoughts. For example, one patient had obsessive thoughts that he might be contaminated with germs. He spent four hours a day washing himself. In therapy, first he watched the therapist contaminate herself with dirt (modeling). He then was urged to rub dust and dirt all over himself (flooding) and endure it without washing it off (response prevention). After about a dozen sessions of covering himself with dirt and just sitting there without washing it off, the thoughts of the contamination diminished and the washing rituals no longer occurred in his daily life.

Behavior therapies, then, focus on the unwanted behavior itself rather than trying to interpret the reasons behind it, and they often employ a kind of 'reverse psychology' by inducing stress in order to extinguish it. Some of these methods are not only anxiety-producing, but also quite unpleasant: e.g., counter-conditioning and covert sensitization both associate the unwanted behavior with either actual or imagined nauseating stimuli, in order to curtail overindulgence or addictions.[322]

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unconscious processes, defense mechanisms such as repression or denial, and the super-ego) are important, helpful, and lasting, and they have found homes in cognitive therapy such as Ellis's RET, and Aaron Beck's Cognitive Therapy, which will be described in Chapter Seven. I will also point out in Chapter Five why Eysenck's claims about the (in)effectiveness of psychotherapy have not stood up to cross-examination.

[320] See Bernstein and Neitzel (1987, pp. 283 ff.).

[321] Indeed, this subsection was originally inspired by my fellow graduate student Gary Hardcastle, who asks, "Why isn't cognitive therapy just behavior therapy?" Ironically, I'll be arguing that so-called behavior therapies are actually species of the intentional or notional-world approach.

[322] Concerning the procedure popularized by J.R. Cautela, Michael Mahoney and Diane Arknoff ("Cognitive and Self-Control Therapies," in Garfield and Bergin [1978, p. 701]) give us this unappetizing description:

"The basic strategy in covert conditioning is to associate imaginally some undesired behavior with unpleasant consequences....To reduce an obese client's consumption of sweets, for example, a scene such as the following might be used. 'I want you to imagine you've just had your main meal and you are about to eat your dessert, which is apple pie. As you are about to reach for the fork, you get a funny feeling in the pit of your stomach. You start to feel quesy,

Before investigating the shortcomings of these methods in practice, let's briefly examine the faults of the *theory* behind them. One thing that behaviorists are mistaken about are the nature of learning in general, and the "learning" of phobias in particular. Behavior therapy's rationale is that disorders such as phobias are learned or conditioned responses, so we have to unlearn or counter-condition them;[323] e.g., we may be afraid of dogs because we were bitten by one when we were young, so we have to learn to relax around them by being exposed to friendlier ones. Although this seems reasonable enough at first, behaviorism's premise that even maladaptive behaviors are *all* reinforced or learned founders on the facts, as most texts acknowledge; e.g., McNeil and Rubin (1977, p. 484) note,

> One limitation of the behavioral approach to phobia is that there are many reports of phobias that have developed without any frightening experience. Many people with severe fear of snakes, germs, airplanes, or heights report that they have had no particular unpleasant experiences with these objects or situations. And many people who have had a bad automobile accident or fall do not become phobic about these situations. Thus, the behavioral model doesn't provide a complete account of phobia.[324]

There are quite a number of problems besetting the behavioral theory here. We've just seen two: fearsome or painful experiences do not invariably result in phobic responses, and some phobias develop even in the absence of such experiences. The correct explanation for the second point seems to be that we are *imagining* that something terrible is going to happen – we *catastrophize*, as Ellis puts it – whether or not our fears are grounded in fact, which strongly suggests that phobias are an altogether more cognitive phenomena than the S/R model portrays. Even behavioral therapists such as Joseph Wolpe (the advocate of the method of systematic desensitization and one-time editor of the *Journal of Behavioral Therapy and Experimental Psychiatry*), have had to concede the inadequacy of purely behavioral explanations and admit that some phobias are quite cognitive, and call for cognitive treatment:

> A person may be inappropriately afraid of a class of stimuli, such as harmless snakes, because he *believes* them to be dangerous, *or* because he automatically responds with fear to their configuration or their movement, *or* for both of these reasons. The treatment indicated for the first of these possibilities is cognitive – the correcting of misconceptions; for the second; it is the deconditioning of anxiety; for the third, it is both. (Wolpe 1977, p. 2)

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nauseous and sick all over. As you touch the fork, you can feel some food particles inching up your throat. You're just about to vomit. As you put the fork into the pie, the food comes up into your mouth. You try to keep your mouth closed because you are afraid that you'll spit the food all over the place. You bring the piece of pie to your mouth. As you're about to open your mouth, you puke; you vomit all over you hands, the fork, over the pie. It goes all over the table, over the other people's food. Your eyes are watering. Snot mucus is all over your mouth and nose. Your hands feel sticky. There is an awful smell. As you look at this mess you just can't help but vomit again and again until just watery stuff is coming out. Everybody is looking at you with a shocked expression. You turn away from the food and immediately start to feel better....' "

This is truly eliminativist therapy, as the authors note ("Nauseating imagery has been the most frequently employed, and many clients do report that these vivid scenarios have emetic properties," *ibid.*). They are quoting J. R. Cautela, "Covert Sensitization" (*Psychological Reports*, 20, 1967, p. 462).

[323] E.g., see Wolpe (1977, p. 1): "Behavior Therapy of the neuroses developed after it was established, first in the laboratory and then in the clinic, that neuroses are conditioned unadaptive habits of response to specific stimulus conditions."

[324] In support, McNeil and Rubin refer us to Davison and Neale's *Abnormal Psychology: An Experimental Clinical Approach* (New York: Wiley, 1974). Cf. also Rosenhan and Seligman (1984, p. 103).

When we recall what phobias *are* – irrational fears – it should be no great surprise that they involve a large cognitive dimension. It's not a *phobia* when someone responds to a clear and present danger by fleeing or fighting, after all – that's a healthy fright response. In phobias, we magnify the risks way out of proportion, for *reasons*: lurking just behind them there are somewhat fantastic *pervasive beliefs* about the feared object; e.g., that the dreaded cats are dangerous, demonic, or just plain bad luck.[325] But why is it that we humans have these hysterical or irrational fears – how do they arise? According to clinicians such as Freud, who have found that phobias and compulsions usually involve either a pathological fear of death, or guilt for a murderous wish or deed, they are the products of our capacity to project into the future and reflect upon, indeed to become obsessed by, the possibility of our own death;[326] e.g., like Howard Hughes, the compulsive hand-washer described above by Rosenhan and Seligman (1984, p. 246) "had the obsession that some terrible illness would strike him if he did not wash." It is these often foolish attitudes that therapists need to 'extinguish,' not some conditioned reflex.

Apart from this fact that many phobias are the results of our wild expectations or "catastrophizing", rather than actual untoward experiences, a further challenge to behavioral theory is the fact that maladaptive behaviors can be changed *without* counterconditioning techniques involving the adverse stimulus itself or even some representation of it (such as movies showing others handling snakes, e.g., which in themselves require phobic subjects to *identify* themselves with the figures they see). Sometimes phobias disappear as the underlying feelings of insecurity are worked through; again, even behavioral therapists point this out, such as Bandura,[327] who argues that the goal of all psychotherapies is actually to change subjects' "self-efficacy expectations" – their confidence in themselves.[328] In addition, as Rokeach points out, *single* session therapies which induce sustained changes by drawing subjects' attention to the contradictions implicit in their values and self-conceptions shows that Skinnerian behavioral theories about the requirements of conditioned learning aren't viable.[329]

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[325] See, e.g., Rosenhan and Seligman (1984, pp. 200-01, 210-11), on cat phobias.

[326] E.g., see Freud, who argues in "Lecture 22: Development & Regression – Aetiology" of the *Introductory Lectures on Psycho-Analysis* (1916-17, **SE** XVI, p. 314), that only humans are neurotic, so the determinant is whatever makes us advanced. A likely candidate would be our reflective consciousness – our capacity to reflect on our own death. On this theme, Freud claims that in his clinical experience (and this jibes with what others say as well) he always find death fears or wishes at the root of obsessions and compulsions and other such symptoms (see *Totem and Taboo*, ch. III, "Animism, Magic, and the Omnipotence of Thoughts," **SE** XIII, p. 87).

[327] You may know Albert Bandura as the one who gets children to punch Bozo dolls via modeling others' behavior. See, e.g., Bourne and Eckstrand (1976, p. 334-35).

[328] See Bandura (1977) on "Self-Efficacy Theory," which Steven Fishman summarizes, in "Limitations of Behavior Therapy," in Dongier and Wittkower (1981, p. 239): "[I]n essence, [it] states that individuals change as a consequence of *experiencing* themselves functioning more effectively, and in doing so are more willing to endure the discomforts of problematic situations long enough to function more effectively or at least with less discomfort."

[329] See Rokeach's interview with Evans (1976, pp. 343-44), speaking of the efficacy of "single-shot" therapy:
"Skinnerian behavior modification requires that a change of the contingencies of reinforcement would involve at least several treatments, so the behavior can be shaped gradually....How would one account for a change observed twenty-one months after a single experimental treatment? And if the observed behavioral consequences are remote, and if there are demonstrable cognitive mediators of those consequences, you have to account for all the cognitive changes that are observed to occur of a single experimental intervention....Therefore, I am left with the interpretation that a single experimental self-confrontation, one that demonstrates a contradiction between a person's values and his self-conceptions, can create an effective state of self-dissatisfaction that has long-term cognitive and behavioral consequences that cannot be accounted for in any other way except to assume they are results of genuine, long-term value changes."

However, a syntactic theorist can perfectly well grant that the behavioristic theory underwriting behavioral modification is mistaken, precisely because it fails to take adequate account of internal cognitive states, which he would identify as syntactic objects. But it still remains open to him to endorse the behavioral therapies themselves, which (apparently) eschew content and projective understanding. Accordingly, let's examine whether behavioral approaches really do avoid the use of interpretation, and let's also examine their limitations.

We'll start with my first claim: to the extent that behavioral therapies are successful, they are actually variants of notional world psychotherapy, not alternatives to it. That much has been argued by investigators such as E. Locke (1971), who has submitted that behavioral therapy isn't even behavioristic, since it violates behaviorism's core premises, such as *epiphenomenalism*,[330] and "the *rejection of introspection* as a scientific method" (p. 318). Using Wolpe's popular behavioral method of desensitization (which has subjects learn to relax and then imagine stressful situations while staying relaxed) as a case study, Locke (1971, 320 ff.) draws on Wolpe's own writings to note how many cognitive activities are involved, on the part of both the therapist and the clients. In the preliminary stages of the therapeutic relationship, even the so-called behavioral therapist has to get patients to *introspect* their thoughts and fears (in order to aid the diagnosis), and to engage the patients' trust and provide encouragement, he, too, has to use *reason* and *persuasion* to *assure* them that they are really not so abnormal and that they can be helped, and often he also has to clear up their *misconceptions* (e.g., that chest pains inevitably signify heart disease). Even though behavior therapy's official premise is that the therapeutic relationship itself plays little or no role,[331] ***empathy*** is needed in this process – if only, as the APA's Task Force on Behavior Therapy reports, "to the extent that this is seen to be important in securing the patient's cooperation with the treatment plan"[332] – because unless you establish a trusting relationship with your patients first by trying to come to a mutual understanding, you're only apt to make things worse.[333] And like true cognitive therapists or critical theorists,[334] Wolpe and his colleague Lazarus even write in favor of what might be called "ideology critiques": "For patients with a strongly moralistic training logical arguments may be needed to convince them of the virtue of standing up for one's rights and the unavoidability (and justice) of hurting the feelings of those who flout those rights."[335] But even the desensitization technique itself employs much more than consistent behaviorism would allow, as Locke (1971, p. 324) explains, since by teaching patients how to relax and then directing them to imagine anxiety-producing situations,

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[330] "*Epiphenomenalism*, as Locke (1971, p. 318) defines it, is "the doctrine that conscious states (e.g.) ideas), if they exist are all, are merely by-products of physical events in the body...and have no effect on either the individual's subsequent actions or his subsequent ideas."

[331] E.g., see Karasu (1977), or Sloane (1969).

[332] APA Task Force Report 5: Behavior Therapy in Psychiatry (1973, p. 27); quoted by Karasu (1977, p. 858).

[333] Patients have to *trust* you before you can have at them with an arsenal of behavioral techniques. If you just try, e.g., a "flooding" technique – lunging at them with a bevy of snakes, say – without having first established a rapport, they will probably become more traumatized by the feared objects than ever, and their phobia will get worse, not better.

[334] Critical Theory is psychotherapy writ large for groups or nations, which seeks to get oppressed people to reflect on their own values and make changes to improve their life. See, e.g., Fay (1975).

[335] J. Wolpe and A. Lazarus, from *Behavior Therapy Techniques* (New York: Pergamon Press, 1968, p. 44), quoted in Locke (1971, p. 321).

> These procedures presuppose, explicitly or implicitly, that (a) the patient has the ability to introspect; (b) he has a mind capable of grasping concepts, understanding questions, and following logical arguments (i.e., that he can think); (c) he has the ability to purposefully control the actions of his own mind and his overt behavior.

Desensitization, implosion, and the other behavioral techniques are quite compatible with a cognitive framework, because therapists *convince* subjects that their irrational beliefs are unfounded by *demonstrating* to them the groundlessness of their worries and fears – and demonstration is a tried and true method of persuading people to modify their propositional attitudes (which is why teachers solve problems on the board). Of course, Locke isn't the only one to find persuasive techniques in the midst of supposedly behavioral therapies, either; e.g., like R.B. Sloane (1969), Jerome Frank (1975), and Arnold Lazarus,[336] Steven Fishman also observes that (successful) behavioral therapists are like other successful psychotherapists in the fundamental respects, and that the bulk of the therapeutic hour is spent in providing understanding and encouragement, not deconditioning.[337]

Given that behavior therapies appear to be variants of notional world psychotherapy, then, since they, too, must employ empathy and reasoning to make progress, now let's explore their limitations. Their major failing, of course, is that they address only a very limited segment of the problem domain. E.g., as Rosenhan and Seligman (1984, p. 246) point out, "The behavior therapies are specific in their effects: obsessive thoughts, compulsive rituals, and anxiety all decrease, but depression, sexual adjustment, and family harmony are not clearly helped." However, since obsessive-compulsives only constitute .3 to .6 percent of psychiatric outpatients (Rosenhan and Seligman 1984, p. 240), and only 5 percent of psychotherapy clients come in because of phobias (Frank 1975, p. 14), clearly behavioral therapies aren't enough, since there are millions more depressed and divorced and many other sorts of unhappy people who could use help, too, as we've seen.

But even for those with anxiety disorders, the behavioral approach alone is often too piecemeal. It may work well enough for very simple problems that can benefit from very simple solutions, such as watching a movie in which people pet harmless rabbits in order to cure a rabbit

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[336] E.g., Smith (1979, p. 35) comments, "Wolpe (1976) appears to be more and more alone in his continued assertion that conditioning is the basis of all therapeutic change," and he quotes this passage from A.A. Lazarus, "Has Behavior Therapy Outlived its Usefulness?" (*American Psychologist*, 1977, p. 550-54), to mark the contrast, of someone who insists that the term "behavior therapy" no longer has any clear denotation: "Those who adhere to more delimited meanings of behavior therapy tend to disregard significant "nonbehavioral" therapeutic developments. they also overlook convincing data demonstrating that in adult humans, conditioning is produced through cognitive mediation: Clinical exigencies demand that a therapist be able to account for events that the behavior therapy model cannot readily explain. Adoption of a more comprehensive (multimodal) framework is required."

[337] See Steven Fishman's"The Limitations of Behavior Therapy," in Dongier and Wittkower (1981, p. 235): "Needless to say, certain individuals are more suited for the practice of psychotherapy than others, and there are certain personal qualities in therapists that serve to secure a therapeutic alliance – such as the well-documented triumvirate of genuineness, understanding, and warmth, as well as the ability to create a nonpejorative climate. These qualities are important factors affecting outcome of psychotherapy regardless of the discipline one embraces, and certainly behavior therapy is not an exception. It may be noteworthy, at least from my clinical experience, that on balance only a small percentage of each therapy hour is utilized for specific behavior therapy techniques. The lion's share of each hour is spent providing understanding support, and encouragement to the client for his intentioned therapeutic steps, and helping the client to generate alternatives to the way he interprets his life situation."

phobia,[338] but it isn't good for much more. Take agoraphobia, for example: it's not just the humanistic psychologists (such as Breggin [1980], Szasz [1961], or Glasser [1984]) who find that agoraphobia is a complicated dependency neurosis which requires insight into underlying marital difficulties and the like – behavioral therapists such as Wolpe acknowledge it as well.[339] The behavioral approach of getting the patients used to visiting one place at a time is clearly an unsatisfactory and partial solution to agoraphobia, which is the result of a pervasive pattern of self-limitation, as, e.g., clinicians such as Breggin (1980, p. 80) have contended; instead, as Fishman (1981, p. 240) argues, an adequate plan of treatment must include

> ...treatment of the insecurities that invariably underlie the manifest phobic behavior. Consequently, considerable time is focused upon independence training, assertiveness training, rational restructuring, and bibliotherapy, all geared at getting the client to experience a sense of autonomy so that she does not have to be "trapped" in (*i.e.*, dependent upon) an unsatisfactory relationship, a dead-end job, or the dictates of controlling parents.

Fishman (1981, p. 236) also points out that therapists who focus exclusively on the phobic symptoms are in danger of being led down the garden path, away from the deeper problems (such as that "they feel like 'imposters' in their chosen occupations"), and he also cautions that even if they do make therapeutic gains, they may be lost as soon as the clients encounter another awkward or humiliating situation, if the behavioral extinction of the fears is not supplemented by attending to the clients' social functioning, as well.

Another serious problem with behavior modification therapies is that they can backfire, because many who are subjected to them find their whole premise dehumanizing and objectionable, with good reason. Nausea treatments and token-economy methods (which reward us at intervals with gold stars or measured praise as if we were schoolchildren) do not seem to be appropriate means of making us become more autonomous and self-reliant. Even if the psychologists find it acceptable, many patients don't – they regard it as degrading, and as a consequence, they become significantly worse. As a case study, consider anorexia. A 1975 text by Fantino and Reynolds (then psychology professors at UCSD) touts the merits of behavior modification in treating anorexics using positive reinforcement (e.g., rewarding them by talking to them, or letting them watch TV if they have a bite to eat), and concludes: "although the patient's history had surely been the source of her problem, the therapist's success in curing the disorder without delving into that history demonstrates that 'working through' is not essential for cure."[340] However, we should not be so easily deceived into thinking a patient has been cured or even helped just because she gains enough weight to get herself discharged from the hospital, because, like as not, she'll lose it all back again soon after she gets out, and what little self-esteem she had will have been destroyed. At least, that's been the experience of the psychotherapist Hilde Bruch, who has worked with about thirty patients subjected to such treatments. In contrast to the behaviorists'

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[338] E.g., see Bernstein and Neitzel (1987, pp. 265-66) on rabbit phobias.

[339] See Wolpe (1977, pp. 2-3): “While all agoraphobics are fearful as a function of separation from "safe" people or places, behavior analyses reveal that only a minority of them are primarily fearful of separation. The primary fear may be of a bodily catastrophe such as a heart attack when out of reach of help, or of strangers or other "dangers" in the outside world. The commonest agoraphobias develop in unhappily married women low in self-sufficiency, secondarily to anxieties that the marital situation generates. Even though in some of these women the agoraphobia becomes autonomous, therapy is never adequate unless it deals with the interpersonal anxieties and related marital problems.”

[340] Edmund Fantino and George Reynolds, *Introduction to Contemporary Psychology* (San Francisco: W.H. Freeman, 1975, p. 551).

superficial analyses of psychological problems (which see the symptoms as the entire extent of the problem), Bruch (1978, p. 645) points out that

> ...both weight loss and food restriction are only symptoms, not the illness. The underlying illness is related to serious developments in personality development, characterized by low self-esteem, severe self-doubt, lack of autonomy, and an inability to lead a self-directed life. The illness becomes manifest when these youngsters are faced with the need for independence and self-assertion after a childhood during which they have been overcompliant to an unusual degree.

Although it may not make much sense to us, the way anorexics *do* assert themselves after all these years is by exerting control over their bodies, which they come to regard as an alien thing.[341] As Bruch argues, it's a mistake to regard their "noneating" as a suicide attempt, and she notes that in her experience, the suicide attempts come *after* the weight has been gained back via the odious means of (token economy) behavior modification, whose darker side is that it punishes failures to comply with "negative reinforcers," as Bruch (1978, p. 646) explains:

> The patient is put in a bare room, deprived of all personal contacts (except with rigidly trained nursing personnel) and all enjoyable activities, and she must earn access to desirable privileges by gaining a prescribed amount of weight. If she fails to do so she will stay in isolation; if there is a loss of weight, tube feeding is threatened or used. The program varies from one hospital to another, but the principle is always the same: make it as disagreeable as possible and give relief only in exchange for eating a prescribed amount of food or gaining weight.

Bruch (1978, p. 646) points out how completely inappropriate this treatment is, given the nature of the problem, since it

> ...completely overlooks the fact that the noneating is related to severe underlying problems, the fear of being helpless, of not being in control. In a way the patient is forced to be her worst enemy, to act against her inner conviction and goals, or suffer the punishment of complete isolation. Invariably anorectics feel out of step with their age group and former friends, and also their families, and they feel extremely concerned with how they rate in the eyes of others. Their sense of worthlessness and of being unrelated is dangerously reinforced by this "nonpampering" procedure of making social contacts dependent on weight gain.

Not surprisingly, many of the patients put through such degrading experiences deteriorate psychologically and become severely depressed and some become overtly suicidal, and the ones she saw lost even more weight once they were released from the hospital. As Bruch (1978, p. 652) puts it, in such cases, behavior modification

> ...undermines the last vestiges of self-esteem and deprives them of the crucial hope of achieving self-determination, without offering support or better self-understanding. Anorexia patients have always complained about their hospital experiences, but not with the same cynical bitterness and sense of utter betrayal that is expressed by those who have been exposed to behavior modification. Uniformly my patients had experienced this program as brutal coercion, dehumanizing, reducing them to utter helplessness, nullifying whatever self-confidence they might have achieved in individual therapy.

Instead of coercing them to eat and producing disastrous consequences, therapists should provide anorexics with "Body-Oriented Therapy" to give them a more realistic appraisal and acceptance

[341] See, e.g. Vandereycken *et al.* (1987, p. 254): "Anorexics are driven to acquire an absolute mastery over their bodies by controlling their internal and external environment, on the physical level (weight, food intake, hunger, tiredness) and on the psychological level (perfectionism, ascetism). They transmute their fear of loss of such mastery into the unabating fear of becoming fat, even while weight loss continues. With each bit of food they assume that their bodies will become disgustingly big."

of their form, and help them to sort out their true feelings, as Vandereycken *et al.*(1987) point out. If they don't, they're just going to get sicker.

Finally, I should directly answer the question, "What's the relationship between cognitive and behavior therapy?" As I noted, many texts classify cognitive therapy as a type of behavior therapy, *viz*., cognitive-behavioral therapy; indeed, Rosenhan and Seligman (1984, p. 112) even criticize cognitive therapy for *just* being behavior mod: "Because behavior therapists and cognitive therapists restrict themselves to an analysis of the discrete behaviors and cognitions of the human being, they miss the essence: that individuals are wholes..." However, cognitive therapy is not so restricted – it does look for underlying cognitions as root causes, and it tries to pull together the whole person and try to get "changes of personality," as we'll see in Chapter Seven. Ellis (1985), for example, grants that cognitive therapy is part of behavioral therapies, broadly construed (pp. 21, 43), but argues that it brings about both insight (p. 23) and profound changes (p. 22). From the cognitivist's point of view, the goal of behavior modification and cognitive therapy is the same: change the underlying unrealistic cognitions and fears that are doing the harm; but cognitive therapy does a lot more than just go after the particular phobias – it examines the person's whole philosophy of life and world-view, if need be, and it brings about global changes by restructuring the client's fundamental attitudes using understanding and persuasion, in addition to such simple behavioral techniques as implosion. But if "behavioral" therapies do this in practice, as well – if they also use empathy and study conscious states – then it is they which are subsets of notional world or cognitive therapy, not the other way around (since as Locke [1971, p. 325] puts it, "To confess that one's implicit definition of behaviorism includes the study of consciousness is to confess that one is *not* a behaviorist").

To a large measure, then, behavior therapies are not alternatives to content-based psychotherapy, they are variants of it. But to the extent that behavioral therapies *are* different because they deny the fundamental importance of the mental, they're inferior, since their premise attributing all our psychological difficulties to reinforcement schedules is faulty; they don't treat people as persons and so they sometimes backfire; and the application of their methods is seriously limited. Thus, the syntactic psychologist cannot appeal to behavior therapies in support of his claim that there is no need for the intentional approach.

Conclusion: Notional World Psychology vs. STM

Let's sum up the case against STM, then. Although Stich claims that a purely syntactic approach can perform all of the scientific duties that the content-based approach can, only better, his claim seems quite unfounded. For one thing, its "explanations" are far from informative or useful; e.g., when a terrorist is holding hostages, we don't want to know that he has some "B-state" underlying his Arabic utterance – we want to know that he's trying to secure the release of some imprisoned members of his organization. For another, it seems that STM isn't even descriptively adequate, since it is unable to reconstruct or reduce phenomena such as self-esteem and other ideas about the self, which have proven to be extremely important categories in clinical practice. It was also found wanting in the area of practical application, as well, because by foregoing interpretive understanding, it falls short in all the areas where hermeneutics does do work for us: in diagnosing psychological problems, in investigating people's cognition, and in helping to

improve it. Thus, STM seems to be a very unlikely candidate for replacing intentional psychology, even if the latter were deficient in the ways Stich alleges.

However, since a *defense* of intentional psychology should do more than point out the shortcomings of its critics' approaches, I shall now examine the substance of Stich's allegations about the limitations of the interpretive approach, to evaluate whether it *should* be replaced post-haste (i.e., whether "the folk psychological concept of belief... *ought not* to play any significant role in a science aimed at explaining human cognition and behavior" [Stich 1983, p. 5]).

Chapter 5: On the Limitations of Intentional Psychology

As we saw, Stephen Stich has leveled a number of charges at intentional psychology in connection with its method of attributing content to people's psychological states: it is "perverse"; too "parochial"; and "unsuitable to serious scientific discourse."[342] In reply, I shall now attempt to either acquit it of these charges or at least diminish their force, by defending the intentional approach on its own merits and continuing to underscore both the utility of empathy in clinical practice and the need for qualified practitioners. I'll begin by taking up the central question which is embodied in the title of Stich's (1983) work, ***From Folk Psychology to Cognitive Science: The Case Against Belief***.

Cognitive Science and the "Perversity" of Intentional Psychology

As Stich (1983, p. 209) states the issue, the question is "whether the folk psychological notion of belief [is] likely to find a comfortable place in cognitive science," and the answer he argues for is that "cognitive science is and should be adhering to the STM paradigm," and hence "there is no place for the folk concept of belief in cognitive science" (*ibid*.).

If the models of cognitive science cleave to sentential but purely syntactic approaches, as Stich (1983) predicts or claims, it may very well be that cognitive science doesn't and won't employ the notion of contentful beliefs or desires. At the time he made this challenge, much of cognitive science *was'* heavily formalistic, and its computer models *did* almost universally employ formal languages as the medium of cognition, since they were implemented on serial machines. Thus, the claim that psychology would be both narrow *and* syntactic then had some weight. However, things are beginning to change with the advent of connectionism or parallel computation, by Stich's own admission.[343] so the prediction about the future of cognitive science already looks dated, within the same decade. But whichever way things go, Stich's way of posing the question

[342] E.g., see Stich (1988, manuscript, p. 3): "like Quine, I view ordinary intentional locutions as projective, context sensitive, observer relative, and essentially dramatic. They are not the sorts of locutions we should welcome in serious scientific discourse."

[343] As I noted last Chapter, Stich (1988) notes that STM may be superseded by connectionism. However, he has taken this in stride and regrouped his eliminativist forces somewhat – Stich, Ramsey, and Garon (forthcoming) argue that connectionism and folk psychology are incompatible, and that PDP is eliminativist. However, pioneer PDP'er David Rumelhart declares, "I believe in representations!" in seminars, and it can probably go either way.

probably has things precisely backwards, for in the historical analysis, the more appropriate question may well be, "Will cognitive science keep a place in folk psychology? Are *its* models (which are described by friends and foes alike as "toy" models) going to prove to be useful or truthful descriptions of the way human beings operate?" Here, the answer is probably "Yes," because some of cognitive science's models can be used to *implement* the mental models implicit in certain schools of psychotherapy. E.g., as we'll see in Chapter Seven, Cognitive Therapy has explicitly incorporated such computational notions as *schemas* to account for facts such as the persistently negative styles of thinking in depressed people.

However, it is unlikely that Stich will be put off the question quite so easily. Instead of tying the fate of folk psychology to the direction cognitive science takes (thereby making an historical prediction), he can press his charges in the form of a more direct challenge to intentional psychology's *current'* scientific status. The suit then boils down to the question, "Is intentional psychology a serious *science*?"

One thing is certain – we have a serious need of intentional psychology or some alternative discipline to help with problems such as neuroses and depression, whose magnitude were reviewed in Section 4.1. But is it a science? Given their familiarity, its theories may not seem particularly sophisticated (although they involve some very theoretical processes, such as unconscious defense mechanisms, as we'll see in more detail in Chapter Six), but intentional psychology is surely an *applied* science, if nothing else. As such, it has cultivated at least the trappings of a genuine science by devising experimental studies to gauge the effectiveness of its methods, as we shall see in Chapter Seven, and there is also experimental confirmation for many of its individual theoretical claims. (E.g., as Edward Lee points out [in conversation], analysts can back up some of their claims about the importance of early bonding and separation anxieties with child development studies, and there are also related animal studies documenting the psychological effects of abuse and neglect on higher primates[344].) However, if Stich wants to insist that despite *whatever* experimental confirmation it enjoys, intentional psychology cannot be a science *because* it employs projective understanding, on the basis of his definition of the objectivist mandate of 'true science', then I guess I'll have to grant him the use of the ***word*** "science," and concede that there is a definite *art* to understanding and persuading people. However, I am reluctant to forfeit the term, since a great deal *does* depend on "who gets to keep the word": a tremendous amount of political and financial clout is granted to those practices bearing the honorific "scientific" that is denied to those thought to be something less. Since we have a tremendous need for psychology's services, and psychology in turn needs the financial support earmarked for "serious science," I'm not going to forfeit the category without a fight.

So the question now is, "Is projective understanding *ipso facto* antithetical to properly *scientific* investigation and explanation?" Perhaps Stich's claim is that it is simply true by *definition* that science must adopt the third-person point of view. However, that implies that science is so biased as to only allow outwardly observable phenomena to be included in the range of the real, forever excluding such important natural phenomena as the inner mental lives of sentient beings from its purview. That seems to be far too narrow a conception of science, however, because

[344] E.g., Maslow's neglected monkeys, whom I discussed in note 16 in Chapter Four. As Elizabeth Bates (in seminar) notes, just like humans, abused monkeys become abusing parents. And as I noted previously, Maslow's colleagues found that a helping relationship with a non-threatening peer (a younger monkey) reverses the cycle.

science isn't an *a priori* discipline with preordained strictures against whole domains of natural phenomena, it is an adaptable empirical inquiry which takes phenomena as they come in the effort to predict, understand, and control them. Since *we* seem to come replete with content-laden inner episodes which mediate our input and direct our behavior, it seems only appropriate for science to investigate and explain us at that level in order to deal with us more satisfactorily, and as we have seen, projective understanding is a most appropriate tool for that task.

Granted, projective understanding is susceptible to abuse: some people anthropomorphize the weather or other natural phenomena, and some psychiatric 'investigators' simply project their own motivations onto others without regard to what they're really thinking, as paranoids do. However, that is not what *good* intentional psychologists do: they are more sensitive, they do investigate, and they continually test their attributions by conversing with and interacting with their clients to come to a shared understanding of the subject's mind-set. Moreover, any science has some poor practitioners who apply it badly, so to disqualify this practice *as* a science, we have to search for deeper reasons than the fact that it *can* go wrong. As we've seen, the reasons Stich (1983, 1984) gives to discredit intentional psychology's scientific status in this context are that intentional ascriptions are "perverse" and especially susceptible to vagueness and ambiguity, and their scope of application is too limited for our clinical needs. Accordingly, in this Section, I shall begin by putting the "perversity" charge to rest, and then I will deal with the complaints about the vagueness and alleged limitations of intentional ascriptions.

The 'Perversity' of Intentional Psychology

Stich (1984, p. 230) charges that the projective method of content ascription (which involves investigators in implicit similarity judgments between their subjects' conceptions of the world and their own) limits intentional psychology to "a Protagorean parochialness...[since] we ourselves are the measure of all things," and he submits, "this is a positively perverse feature to build into a language in which we hope to do science." In reply, I shall be arguing that it is not "perverse" for intentional psychologists to adopt themselves as the measure of other people's psychology, particularly in applied, clinical settings.

Of course, psychology is not the only practical science which uses "man as the measure of things": in engineering, we gauge the girth of objects by our own measure – the foot – and we assess their relative strength and density by testing them against our own (e.g., by sitting on them to see if they will bear our weight). Similarly, in medicine and biology, investigators judge defective organs according to the standards set by more normal specimens.[345] Or consider another applied discipline which deliberately and sensibly employs "Protagorean" criteria: education. We judge people's performance, intelligence, and the rate at which we should present them with new information and expect them to learn it relative to their peers. If we don't, we can produce disastrous consequences, as when James Mill subjected his son, John Stuart Mill, to an extremely intense and precocious education, which resulted in the latter's breakdown at the still

[345] Patricia Kitcher suggested the relevance of biologists' using normal specimens to measure defects to me.

tender age of nineteen.[346] Judging by these examples, then, there doesn't seem to be anything "perverse" about a discipline's being Protagorean.

Similarly, "Protagorean" methods are needed to ***diagnose*** people's problems, as we saw in Chapters Three and Four, since we judge whether people's fears are irrational or their ideas grandiose or delusional according to more standard conceptions of their situation, and the way the rest of us behave.[347] Such is the pragmatics of psychology: one of its tasks is to compare us to one another, and another it to try to bring us more in line with one another (e.g., some people quickly become enraged over minor insults, and therapists need to point this out to them, in order to help them get along with others better). If this seems a "perverse" thing to do, just try to run an ordered society without making normative judgments relative to social expectations and norms.

Moreover, as we also saw in Chapter Four, "Protagorean" methods are also useful in helping subjects to *overcome* some of their problems. There are at least two quite different ways of trying to bring about the fundamental personality restructuring that is required to relieve the suffering of (for example) the distressed veterans, or the victims of rape, incest, abuse, and neglect described in Section 4.1. We can scorn the "perverse" interpretive methods and treat humans ***as*** objects or elaborate input-output devices such as Coke machines[348] which can be understood by simply reading off their objective behavioral properties without having to draw yourself into them, and which require objective means of intervention to rectify their breakdowns. However, as I hope to establish in these Parts II and III, these de-humanizing treatments have bad results, partly because "patients" find them unacceptable. The other means of treatment, which is characteristic of the person-centered psychological paradigm, as we saw in Section 4.2, is to use Protagorean methods which treat human beings as subjects or persons: with warmth, respect, and empathy. Part of the picture is that people are like *texts*, in that to make sense of us we must be ***interpreted***, and to make any headway in changing us, therapists have to try to understand the significance our actions hold for us and reason with us about the validity of our attitudes, and this requires them to map their notional world onto ours in order to empathize with us.[349] If you do less than this, you're simply not doing justice to the phenomena; the reason for this is probably that we *are* persons, but rather than arguing metaphysics, my only contention here is that for practical purposes it is best to assume that we *are* persons, and treat us as such.

In short, an investigation of our clinical needs reveals that empathy, the very feature of intentional psychology that Stich terms "perverse," is one of its most beneficial and important

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[346] After spending his childhood learning Latin and logic and mathematics and other marvelous but stifling subjects, John Stuart Mill wrote in his *Autobiography* that he was only able to regain his humanity as the result of discovering the English Romantic Poets' love for Nature.

[347] E.g., in some societies, seeing and responding to religious visions is not only considered non-pathological, it is a desirable trait. It would be inappropriate to try to disabuse them of their notions there, but if they emigrated, it's a different story. See, e.g., Westermeyer (1987).

[348] The Coke machine is Fodor's inauspicious example in his 1981 *Scientific American* article on functionalism.

[349] See my Section 4.3 on the importance of empathetic understanding in psychotherapy; or here is R.D.Laing (1960, p. 35) on the same theme: “The personalities of doctor and psychotic, no less than the personalities of expositor and author, do not stand opposed to each other as two external facts that do not meet and cannot be compared. Like the expositor, the therapist must have the plasticity to transpose himself into another strange and even alien view of the world. In this act, he draws on his own psychotic possibilities, without forgoing his sanity. Only thus can he arrive at an understanding of the patient's *existential position*.”

aspects. Empathy is as appropriate to psychology as "having a good ear" is to piano tuning – things are just going to get worse without it. Projective understanding is unique to the social sciences, but it's not as though science has only one accepted means of investigation – it all depends on the phenomena, *and* our relation to it *and* our capabilities. A method of investigation that is eminently appropriate in one domain (e.g., histology) would be ridiculous in another (e.g., micro-particle physics, where the critters they study are too tiny to stain). Similarly, there is no reason to fault intentional psychology for adopting empathy as the means of understanding what others are thinking and feeling simply on the basis that it is not a method used in the other sciences, since different sciences studying different phenomena each have their own relative means of measurement appropriate to them. Since people certainly do appear to have content laden states to be discerned (unlike other sorts of natural phenomena), and since the intentional psychologists investigating us do have insight into the human condition insofar as they *are* humans and know something about it first-hand, it would be a bad idea to enjoin them to put this knowledge aside in order to revert to more superficial means of observation or analysis, especially since the very act of so understanding someone can prove to be quite beneficial, as we shall see in Chapter Seven.

Granting, then, that projective understanding is an *appropriate* means of investigation for this domain of inquiry, despite being "parochial and Protagorean," let's examine to what extent it may nevertheless be *too* parochial in its scope of application.

Is Intentional Psychology *Too'* Parochial?

Stich's most serious allegation against the applied science of intentional psychology is probably that it is insufficient in its scope application: he claims that projective understanding is far *too* parochial. But is it?

Since it *is* an applied science, psychology's first responsibility surely isn't to be *universal* in scope by being sufficiently abstract or vague to be able to accommodate any *possible* cognitive systems; rather, its mandate is to benefit those within its actual problem domain. We musn't let our enthusiasm for "the logical space of possible cognitive systems" (see Stich [forthcoming]) distract us from the needs of the very present and populated space of actual and unhappy cognizers. Thus, our question should not be, "Can intentional psychology do *everything*?" but rather, "Does it do *enough* to warrant its continued support?" So the issue is, of the *relevant* domain – human beings – does it exclude too many cases to be a satisfactory or self-respecting applied science? And the answer is, I shall be arguing, "No – it is not the case that the application of intentional psychology is so limited as Stich alleges." To see why, let's go back to his cases and examine them, case by case.

"Exotic Folk"

Recall that Stich (1983) faults intentional psychology for being unable to accommodate the cognitive states of "exotic folk." As I shall explain, these cases are actually red herrings, but I will examine the example he gives, anyway, to rebut his contention that other cultures' beliefs are so absurd as to be non-sensical.

The example Stich (1983, p. 98) gives concerns the Nuer, who apparently believe that "a sacrificial cucumber used in certain rituals is an ox!" Claiming this is "so hopelessly beyond belief, so absurd, that it boggles the mind how anyone could possibly believe it," Stich (1983, p. 101) charges that such cases of "patently absurd" beliefs strain intentional psychology's resources to its limits, and catch it in "a whiff of contradiction":

> On the one hand we are inclined to say that a suitably mad person might perfectly well come to believe that a cucumber is an ox or some other patently absurd claim. On the other hand we are inclined to say that if a person's inferential capacities are that far gone, then no content sentences in our language will adequately characterize his belief states.

However, while I agree that this particular notion does seem far-fetched, it is not so absurd to be unintelligible. Like other religious beliefs, it reflects their ideas about the interplay of natural and social forces, as Stich himself notes (1983, p. 99), while drawing on the same anthropological study that informed him of the belief.[350] It's certainly no crazier an idea than the Catholic notion that when consecrated bread and wine are ingested at the appropriate place and time, they are *transubstantiated* into becoming an incarnation of the 'Holy Son' *inside* ***each*** believer, a notion which many of our fellows apparently accept or even believe. These "absurd" beliefs that stretch our powers of comprehension ***are*** worth taking seriously and we should honestly try to interpret them, because they can be of such paramount importance to those who hold them (e.g., some people are willing to kill for them, and to engage their country in a civil war with those who deny the legitimacy of their sacraments). But despite their strangeness, we *can* comprehend other culture's beliefs if we open ourselves to them and take the trouble to learn what they have to tell us, as the very anthropological reports informing us of them illustrate.

This brings us to my claim that these sorts of cases are red herrings. Stich seems to be inviting us to commit a quantifier error by faulting psychology because some investigators find some subjects incomprehensible. Naturally, cultural differences ***are*** barriers to understanding "primitive" or "exotic" folk, and for any given investigator, there are probably millions of subjects he won't be able to make head nor tail of. However, it is not necessary that any untutored man on the street be able to understand any given subject – just that *some* psychologist or other can.[351] Granted, a Beverly Hills analyst would probably find exotic tribesmen and inner-city ghetto youth equally alien to his thinking, and be unable to produce constructive changes in either of them, but this is not a problem with psychology *per se*: "exotic" folk should find therapists who have similar backgrounds, just as people who own foreign cars should go to specialty garages. The fact that the mechanic or therapist requires some familiarity with the type of person or car that it is before he can be of help certainly does not show that there is something wrong with psychology or automotive mechanics. We should not be moved by an *a priori* plea for a universal science, since people (and cars) are quite different from one another, and there's only so much an investigator can learn about the range of cases in his domain within his lifetime. (Although given an *infinite* amount of time, any competent investigator may be able to immerse

[350] Stich draws on the work of E. Evans-Prichard: *Nuer Religion* (Oxford University Press, 1956).

[351] Note that it's not the case that just any man on the street could explain anyone's behavior in syntactic terms, either: even the syntactic psychologist is going to need special training in sentential models, and as anyone who has taught it knows, some people find propositional calculus an even more alien way of thinking than the metaphysical beliefs of exotic tribesmen.

themselves sufficiently in any human[352] culture to find out what they think.) As long as we have clinicians with varied backgrounds, there is no problem: intentional psychology as a whole can continue to accommodate troubled people of all types. Even though no one psychologist could treat everybody (any more than any one doctor could know enough about all possible ailments to be able to treat all of them competently), Stich has given us no reason to think that some subjects will be incomprehensible to all psychologists.

So while Stich is right in asserting that we can only understand people if we are sufficiently alike, it is not the case that intentional anthropology is impossible. If it were, he would not have been able to present the case of such strange or exotic metaphysical beliefs in the first place! Ironically, the lesson to be drawn from these anthropological cases is that the limits of empathic understanding are not rigidly fixed – cosmopolitan therapists can greatly extend the scope of the circle of friends that they *can* understand. With training, education, diligent investigation, and sensitivity, imagination (and perhaps the indigenous mind-altering drugs), the therapist can extend himself: he can come to inhabit several notional worlds, and understand foreign clients by getting himself to think more like them.[353]

But can psychologists or anthropologists do this in a sufficient number of cases? Let us consider now the second class of cases Stich presents as being beyond the pale of intentional description.

Those With Physically Impaired Brains

This time he is right: some seriously brain-damaged subjects are beyond the pale. Stich (1983, *passim*) discusses "Mrs. T," someone in the later stages of extreme Alzheimer's disease, who can *say* "McKinley was assassinated," but no longer knows who McKinley was, or even what assassination is. This is *not* an appropriate test case for intentional psychology, however, for such patients arguably cease to have propositional attitudes altogether once we can no longer understand them, and so they should not be expected to be within the purview of a discipline that tries to understand people's thoughts.[354] Those with *radically* abnormal psychologies like the case of Mrs. T that Stich describes, and those with *extreme* brain injuries and degeneration probably aren't persons, anymore, once we can make *no* sense of them at all, since their capacities have been reduced to the stage that they can only utter fragments like a parrot.

Of course, this wouldn't be a satisfactory response if some more universal science *were* able to understand and help them. However, this is not the case in these extreme cases – after a certain point, these people are *beyond* help, as is a completely rusted-out car with a blown-out engine. Short of a brain-transplant, which would produce a more fully functioning person only by destroying what was left of the old one, there's nothing much we *can* do for people with

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[352] Extra-terrestrials be damned (until we have "Close Encounters," at least): clinical psychologists only have to deal with humans. They can also help animals, but humans are their primary responsibility.

[353] See Rogers (1951), Laing (1961), Szasz (1961), etc.

[354] After a certain point, the brain damaged simply cease to have meaningful thoughts. (Just don't ask me at *what* point.) Indeed, the argument pertaining to "Mrs. T" that Stich does make isn't so much against intentional psychology as it is for the holistic nature of belief (see Stich [1983, pp. 54-56): without *enough* belief-like sentences, one fails to have *any* beliefs. Searle (1983, p. 20) makes an analogous point about holism using a stone age man tokening the sentence, "I want to run for the Presidency of the United States."

degenerative diseases and irreversible brain damage. Although Stich claims that the virtue of his approach is that it can make generalizations about the way such subjects are cognizing even though we can make no sense of *what* they are cognizing,[355] the sad fact is that when they reach this stage they no longer do much cognizing at all, and about the only thing we can do with them is to try to keep them calm and content – i.e., we end up tranquilizing them and, if they're lucky, letting them watch TV. Before they are too far gone we try to make the most of what they've got by giving them occupational therapy and trying to engage them at their level, but let's grant that beyond a certain point there's not much we *or* anyone else can do.

Instead of the extremely senile and brain-damaged whom no one can help, then, the test cases for intentional psychology should be the remaining cases Stich mentions: young children and schizophrenics, the subjects within the province of psychiatry who are maximally unlike the "normals" of their society trying to help them by interpreting their attitudes. As I shall now illustrate, with patience, investigation, and "educated guesses"[356] we *can* understand the cognition of children and schizophrenics, despite their differences from us; let's take the former first.

Intentional Developmental Psychology

As we saw in Chapter Three, intentional developmental psychology *is* possible: clinicians *do* have an understanding of the mental life of small children, of their nascent folk psychology (projecting animate and intentional properties to explain how things behave) and somewhat different categories and conceptions. With training and investigation we can come to see things from their point of view, even as they are struggling to grasp ours.

But Stich raises troublesome cases involving gray areas: just how do we tell when a child (or anyone else, for that matter) has learned our concept or not? As it happens, they involve both his children, one at the beginning stages of learning arithmetic (see Stich 1983, pp. 143-44), the other along the way to knowing what "$E=mc^2$" means (1983, pp. 85-86). Since these represent intermediate cases involving standard sorts of prototypical judgments and not a principled difficulty, I will keep my response brief.

Stich rightly notes that the younger subjects are, the greater the difference is between their concept of number and ours. At a certain stage, they can count to 6 all right, but unlike we who can add 6 to any figure, they sometimes get lost after the sum is greater than, say, 12. So do they have the "6" concept or not? Well, it's unclear – it depends on what we're asking: can they count to six, or do they understand what arithmetic is and know that "6" is a functional role concept embedded in formal relations with many other syntactic objects? When the question is "Do you know how many points there are on the Star of David?" they'll answer "six," all right, but strictly speaking we ought to star their concept when we report their belief-content to note their imperfect grasp of the notion. The moral Stich (1983, p. 144) wants to draw from this is "what is needed to capture the generalization is a taxonomy of mental states that is oblivious to ideological similarity." By all means, let's grant Stich (as I did back in Section 4.3.1) that

[355] See Stich (1983), pp. 142-43, 158-59.

[356] This phrase is invoked by T. G. R. Bower, in *The Perceptual World of the Child* (Cambridge, Mass.: Harvard University Press, 1977).

sometimes we need syntactic generalizations, too. However, the fact that there are borderline cases does not raise a major difficulty for interpretation theory. Similarly with the "$E=mc^2$" case: there is a continuum between the points at which someone can utter "e-equals-emcee-squared" without having any idea what it means, and the point at which he has a passing knowledge of its content, but the context of the question about what he actually believes (e.g., a game show (see Stich 1983, p. 86) or a hospital ward (where it may not matter much if he really knows what he is saying), or a physics exam (where it does) will determine how important the ideological similarity is, so again, there is no great difficulty for intentional psychology here.

Let us turn now to schizophrenic cases.

Leon Gabor: Christ or Dung?

In addition to his hypothetical cases about ways people's cognition ***might*** break down,[357] Stich (1983: 101) describes a case of an actual patient:

> The clinical literature is full of reports of people who say absurd things and whose reasoning capacities are clearly impaired...the descriptive apparatus provided by common sense just is not up to characterizing the patient's cognitive states. When a man insists, apparently in all sincerity, that he is Jesus Christ and that he is a heap of dung, there is no comfortable characterization of his beliefs.

Stich is talking here about Leon Gabor, one of the schizophrenic ***Three Christs of Ypsilanti*** studied by Rokeach (1964). Granted, there is no ***comfortable*** characterization of his beliefs, since we are not comfortable with someone who thinks he is Christ, ***or*** dung, much less both. But it is not so hard to understand poor Leon's feelings once we realize that he is very confused about his identity, and that, like many schizophrenics, he has both extremely grandiose ideas about his ***ideal*** self (who he "really" is "deep down," or would like to be) and extremely critical ideas about his ***perceived*** self, because of low self-esteem and high expectations.[358] Part of him thinks (or wants to) that he is great, and this manifests itself at different times, but part of him thinks he is lower than low – that part took precedence after Rokeach deliberately placed him in the experimental situation of being confronted by two other schizophrenics also claiming to be

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[357] E.g., Stich (1983, 70 ff.) describes Dave1 through Dave9, who successively lose their logical rules of inference, as if we do think according to rules of inference, or could lose them one by one.

[358] For an account of the ideal self-representation "communicated to the child by the parents, or based on the child's distortions of the parents' wishes or reactions," see Sandler and Rosenblatt (1962, p. 132) regarding psychoanalytic theories; Ellis, Ross, and Beck have similar notions, or see Jackson (1984, pp. 43-44, 194-99). The relevance of self-representations for delusions is set out here by Arieti (1979, p. 114):

> ...many delusional ideas are based on lack of self-esteem or on a very poor opinion or image that the person has of himself. A common example is the patient who has the idea that people laugh at him. He actually hears them laughing. He turns his head; he looks at them and has the impression that they smile and ridicule him. ...The therapist will help the patient to recognize that he sees or hears people laughing at him when he ***expects*** to see or hear them...[and feels people ***should*** laugh at him because he is a laughable individual....What he thinks of himself becomes the cause of his symptoms.
>
> ...At times low self-esteem leads instead to symptoms grandiose in content. A person who considers himself Jesus Christ or St. Paul or Einstein...is a person who has an unconscious vision of himself that is very low, frequently horrendous. He tries to deny this vision by believing that he is superhuman or one of the greatest human beings living or dead.

Christ. Despite the Eucharist, all three knew they couldn't ***all*** be right, so something had to give. Accordingly, Leon, the more passive personality, went through a transition of identities, from "*Dr. Domino Dominorum et Rex Rexarum*, [and] *Simplis Christianus Pueris Mentalis Doktor*, [and] the reincarnation of Jesus Christ of Nazereth to Dr. R. I. Dung."[359] Notice that the last "name" which Stich picked up on is actually a (slightly ungrammatical) ***question.*** Like many schizophrenics, Leon uses somewhat disguised forms of communication. Once we recognize these name changes as manifestations of his search for identity, his apparently absurd beliefs are not so difficult to understand, as Rokeach himself points out.[360]

Analogously, other sorts of (slightly more realistic) delusions, such as, "When I get out of here I'm going to fly to Scotland where they are making the movie of *Fiddler on the Roof* because I'd really like to try out for the lead" – uttered by a young patient some years ***after*** the film had been made (see Brown 1973: 399) – probably represent attempts by the patients to boost their self-esteem by defining some sort of ideal identity for themselves more important than the ones they occupy as mental patients.

Thus, even in the apparently absurd case Stich selects, we ***can*** make sense of schizophrenics' delusions as an attempt to cling to some kind of ideal identity which can withstand the assaults of their own punitive super-ego. Of course, Stich can counter that I just got lucky in making sense of this particular case which he perhaps injudiciously selected, but I have hardly addressed the larger issue of whether we can in general make sense of schizophrenics, whose speech tends to be quite bizarre. That's a fair challenge, so let's investigate schizophrenic cognition in more detail.

But I don't want to leave the impression that the cause or source of all delusions are best understood in intentional terms. In some cases, the delusions many schizophrenics cling to are probably the results of their attempts to account for the abnormal sensations they are being subjected to, as Maher (1974), Torrey (1983), R. Anscombe (1987), and others argue. Acute schizophrenics seem to find it difficult to exclude stimuli irrelevant to their current task, or confine their attention to one particular set of sensory input, or distinguish figure from ground;[361] these attentional and perceptual disorders (which may very well be due to neural deficits rather

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[359] See Rokeach (1968: 151), and Rokeach (1964, *passim*).

[360] Rokeach, a social psychologist, was interested in the ***functions*** that people's attitudes have: e.g., they can help us to secure pleasure; or protect our ego from basic truths about ourselves or from harsh realities of the world; and they can have a "knowledge function" that gives meaning to our lives. (This truncated list of the functions of our attitudes derives from Katz [1960, "The Functional Approach to the Study of Attitudes," which is endorsed and quoted by Rokeach [1964 and [1968.) When we understand this, Rokeach (1968: 131) explains, we are in a better position to understand delusions, and he refers to his three 'Christs' to make the point:

> ...a particular function may be judged present when viewed from an inside, phenomenological viewpoint, but absent when viewed from an outside, objective viewpoint. In my research with three chronic paranoid schizophrenics (1964) it was found that various delusional beliefs served not only last-ditch, ego-defensive functions, but also knowledge functions. Delusions represent a search for meaning, giving the person holding them the illusion of understanding even though they are grotesque, ego-defensive distortions of reality.

[361] See Maher (1974: 101); Maher (1974, 1983) cites a number of studies in support of the idea that schizophrenics suffer from an attentional deficit, including Venables (1964); McGhie and Chapman (1961); and A.H. Lang and P.J. Buss, "Psychological Deficit in Schizophrenia: I. Affect, Reinforcement, and Concept Attainment," and "II. Interference and Activation," ***Journal of Abnormal Psychology*** 70, 1965: 2-24, 77-106. See also R. Anscombe (1987), who provides some more current references.

than psychosocial abnormalities[362]) generally precede the ensuing delusions, whose content frequently concerns unusual bodily sensations which others don't share, and which tend to occur in more intelligent schizophrenics, who are able to explain these strange events they are experiencing as being due to some divine agency, or the machinations of the CIA, the church, aliens, or whatever – depending upon the intensity and desirability of the experiences, the subjects' cultural background, and whether they have any significant episodes in their history which could account for their being singled out for such extraordinary treatment.[363] Consequently, the deluded subjects either feel persecuted and victimized, or grandiose and superior to the rest of us. In either case, their attitudes make sense, once we take into account the character of their experiences – they become "stuck" on certain stimuli without being able to voluntarily shift their attention – and we adopt their frames of reference, which attempt to account for their aberrant states of mind. As Torrey (1983: 23) puts it,

> ...most delusions and hallucinations, as well as distortions of the body boundaries, are a direct outgrowth of overacuteness of the senses and the brain's inability to synthesize and respond appropriately to stimuli. In other words, most delusions and hallucinations are logical outgrowths of what the brain is experiencing. They are "crazy" only to the outsider; to the person experiencing them they form part of a logical and coherent pattern.

Not only is it possible to understand the content of psychotic people's delusions in these terms, but those who have to cope with such individuals on a daily basis such as psychiatric nurses have found that it is also therapeutically important to do so, and to help the patients come to this understanding, as well. E.g., Haber *et al.* (1987: 762-64) illustrate and explain here how and why therapists should approach both types of delusional beliefs in this manner:

> In general, the nurse must try to understand the client's private world, what it means, and why the client has retreated into it. When clients sense that the nurse is trying to understand their conflicts, fright, and pain, they become more trusting and confident in the nurse and feel increasingly free to share their perceptions and feelings. The nurse can then become a bridge for the client in defining reality.
>
> ...The nurse's communication should avoid supporting and reinforcing the client's delusion. However, the nurse should not attempt to attack or challenge the delusions. This would strip the client of a necessary defense against overwhelming anxiety and might precipitate an outburst of uncontrollled assaultive behavior. Rational explanations will only make these clients adhere more firmly to their delusions. Instead, nurses may cast doubt on the validity of the clients' thoughts. For example, a client who expresses the fear that someone is plotting to kill him may be able to listen to a nurse who responds by saying, "I sense that you are feeling frightened right now. You are safe on the hospital unit. I would like to spend time talking with you about the concerns you have that are frightening you right now." This shifts the focus from the imaginary killer to the client's real fears and concerns. As the client's anxiety level decreases, the delusion dissipates. The client needs to be helped to relinquish the delusion without losing face. The following example illustrates the client's growing awareness of the unreal quality of the delusion and the nurse's role in facilitating this process.
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> > GERRY: I remember that when I first came here, I thought I was God. I heard voices, too. It feels like part of a different person.

[362] E.g., see the "Biology of Attention," by S. Matthysse in ***Schizophrenia Bulletin*** 3, 1977: 370-72, which Maher (1983: 47) cites in this context.

[363] See Maher (1974, *passim*) or Anscombe (1987: 250-52) for such an account of the origin of delusions, and see Torrey (1980: 151-52) for comments on how the content of delusions varies in different classes and cultures: some invoke high-tech machinery or aliens to explain what is happening to them, others, deities, demons, or government agencies.

> NURSE: When you first came here, you felt very negative about yourself. Your identification with God was a way of eliminating those feelings. Now that you're understanding yourself better, you are able to look at yourself in different ways.

Similarly, Norman Cameron (1974: 690-91) explains why it is useful to engage in talk therapy with paranoids:

> This writer favors an interested, attentive, relaxed, and unaffected attitude, with an unfeigned air of detachment and suspended judgment....There is no difference of opinion about the necessity for scrupulous but not cruel honesty, for respect, truthfulness, and steadfastness. What the patient needs is not merely a chance to talk and "ventilate" his feelings; he needs to break out of his isolation, and share his fright, anger, and resentments with someone who does not take sides or pretend to know everything. The therapist must become what one of my own patients called "a new point of reference," a person who gives the patient the chance to catch glimpses of his own personal world from another's perspective. An indispensable therapeutic goal is that of replacing a pervasive, uneasy suspicion and mistrust with a specific confidence, which then forms a new base for further explorations by the patient. One must always remember that it is not the delusion that calls for therapy, but the frightened person; sometimes, a paranoid regains effective social health without entirely giving up his delusional beliefs. This is as real a recovery as that of a diabetic who learns to regulate his life independently without ever losing his original vulnerability to diabetes.

However, eliminativists can counter that it may be possible to make sense of and even help with schizophrenics' delusions, but this hardly addresses the larger issue of whether we can make sense of schizophrenics' speech in general, which can be quite bizarre. That's a fair challenge, since, as the diagnostic category of "schizophrenia" indicates,[364] and as we saw in Chapter Three, many schizophrenics have disordered thinking and bizarre speech which can be notoriously difficult to follow. Accordingly, let's investigate schizophrenic speech in more detail, since it probably poses the severest strain on intentional psychology's interpretive resources.

Making Sense of Schizophrenics

As we just saw, even in the apparently absurd case Stich selects, we ***can*** make sense of schizophrenics' delusions as an attempt to cling to some kind of ideal identity which can withstand the assaults of their own super-ego. But what about understanding schizophrenic speech in general? As the diagnostic category of schizophrenia indicates, and as we saw in Chapter Three, schizophrenics have disordered thinking and bizarre speech which can be notoriously difficult to follow, in addition to their delusions, hallucinations, and problems of identity.[365] Since they probably pose the severest strain on intentional psychology's interpretive resources, their speech warrants further consideration in the face of Stich's charges.

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[364] See the DSM-III (1980, 181 ff.), which lists diagnostic criteria for schizophrenia concerning delusional content of thought; loosening of thought associations; hallucinations; blunted or flat affect; confusion about their identity; reduced motivation; autism or withdrawal from the world; and abnormal psychomotor behavior such as rocking, or bizarre rituals

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Of course, I could try to dodge the issue here by pointing out that schizophrenics only comprise about 1% of the population, and arguing that as long as intentional psychology can accommodate the other 99%, it shouldn't be faulted. However, there is no need to resort to such plea bargaining, because once we recognize their cognitive peculiarities for what they are, we ***can*** make sense of even schizophrenics if we approach them at their level. However, since we have already seen many of these points in Chapter Three, I shall just reprise them briefly here.

As we saw, when schizophrenics are tested on sorting or classification tasks, they are prone to ***overinclusion*** – they extend their categories far beyond the way we normally do.[366] And as we also saw, their speech is prone to a lot of ***fusion***, where the subjects' obsessions, wishes, delusions, feelings of remorse, and so on break in on their consciousness and complete the sentences they began (see, e.g., Cameron 1944: 56). And even when it doesn't interrupt itself, schizophrenic speech uses a lot of ***metonymy*** to refer to or with episodes from their lives (*ibid.*), and they also use a lot of ***neologisms***. The question is, with these characteristics, are schizophrenics beyond the pale of intentional understanding – are they too strange to make sense of?

The first thing to notice in response is that there are lucid moments when schizophrenics inhabit notional worlds more or less the same as our own, and they make perfectly good sense. In these lucid periods, we should try to get through to them, and lay the groundwork for understanding them in their psychotic phases. But can we understand them even in their psychotic phases, when they act and speak bizarrely? According to those who ***have*** investigated them, such as the contributors to J.N. Kasanin's excellent (1944) anthology, ***Thought and Language in Schizophrenia***, yes, we can understand schizophrenics even then – ***if*** we take the time and trouble to learn about them, we can discover the meaning of even their sometimes frustratingly private symbols.

As I have indicated, the Kasanin volume reveals that there are a few basic reasons why it is difficult to understand schizophrenics: they tend to speak in an idiolect, partly because they have difficulty in adopting our point of view;[367] many have either lost or renounced our way of abstracting, adopting instead what clinicians call the ***concrete attitude***;[368] and they are subject to

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[366] This theory about the presumed defect in the "filtering" of attention, which is usually attributed to D.E. Broadbent (*Perception and Communication*. Oxford: Pergammon Press, 1958) originally, has been forwarded by Payne (1966), Maher (1972, 1983), and many others to account for the shift in schizophrenics' cognitive performance over time

[367] E.g., see Sullivan (1944, 14-15) for his account of the defective "fantastic auditor" in schizophrenics checking their utterances for adequacy, or Cameron (1944, p. 55), or a number of more recent investigators who have taken up the idea and called it a problem in "self-editing" or "impaired perspective," including Harrow, Lanin-Kettering, and Miller (1989); Davis and Blaney (1976); Bertram Cohen *et al.* (e.g., see B. Cohen, G. Nachmani, and S. Rosenberg, "Referent Communication Disturbances in Acute Schizophrenia," *Journal of Abnormal Psychology* 83, 1974, 1-13; or B.D. Cohen, "Referent Communication Disturbances in Schizophrenia," in Schwartz 1978); or D. Rutter (see his "Language in Schizophrenia: The Structure of Conversations," *Bulletin of the British Psychological Society* 35, 30 ff.). As Rutter (1982, p. 613) puts it, "Schizophrenic patients whose language is disturbed find it difficult to take the role of the listener and fail to structure what they say in a way that is easy to follow and reconstruct. Their disturbance lies not in regulating and organising their thoughts, but in expressing and communicating them."

[368] 1. E.g., see M.H. Johnston and P.S. Holzman, Assessing Schizophrenic Thinking (San Francisco: Jossey-Bass, 1979) for one such scale. The proverb "The wife is the key to the house" is from the Gorham Proverbs Test, which continues to be used by a wide variety of investigators (e.g., Harrow *et al.* 1986) and clinicians to detect the "concrete attitude"; see D.R. Gorham, "Proverbs Test for Clinical and Experimental Use" (Psychological Reports 1, suppl., 1956, 1-12), or "Use of the Proverbs Test for Differentiating Schizophrenia from Normals" (Journal of Consulting Psychology 20, 1956, 435-40). The Rorschach is still used by investigators such as Spohn *et al.* (1986). Similarly, some tests of concrete versus abstract thinking may elicit negative results because the subjects are overinvolved with the material, as

"intrusive thoughts" and memories which break into whatever they were speaking about, resulting in the fusion. When we take these into account, and spend the necessary time and effort in getting to know them and finding out about their background, we can understand their idiosyncratic references a good deal more. If they won't or can't come to us, as it were, by adopting our perspective when they attempt to communicate with us, we must come to them, and learn about their state of mind and the traumatic events in their life that keep intruding into their consciousness in order to follow their speech.

To start with, if we make inquiries to their family and friends, we may be able to find out about significant episodes in their lives which might be responsible for their underlying conflicts which manifest themselves in the intrusive thoughts and fused speech. Once we do so, much of their speech will cease to be so baffling, when we know enough about them to recognize what is happening, and identify their apparent digressions.

Similarly, schizophrenic speech is also comprised by a lot of ***metonyms*** which are related to episodes in their life; e.g., as Cameron (1944: 54) notes, "One patient says that he 'has menu three times a day' instead of food or meals." These imprecise or misleading allusions do make it very difficult to follow them, but their idiosyncratic references ***can*** be decoded to make sense of them, as Cameron (1944: 54) comments: "Taken in the frame of the individual patient's life and his known fantasies, these sentences can be translated into more precise, socially current forms."

Finally, when we take sufficient account of the mind-set of the concrete attitude, we can understand schizophrenics much better. In concrete behavior, as Goldstein (1944: 23) explains, "we are governed, to an abnormal degree, by the outer-world stimuli which present themselves to us, and by the images, ideas, and thoughts which act upon us at the moment;" in the concrete attitude, "there is an abnormal boundedness to outer-world stimuli so far as they belong to that realm of reality which the patient experiences." In other words, schizophrenics are more data-driven than the rest of us. Once we understand that, Goldstein (1944) argues, we can begin to understand both their symptoms and their symbols better:

> ...from the point of view here advanced many strange symptoms in schizophrenics become intelligible. We can understand them as reactions which are commensurate with the changed world of the schizophrenic, a world which is pathologically concrete and void of abstract interpretation. (p. 34)
>
> ...many of the very strange words which the patient uses become understandable when considered in relation to the concrete situation which the patient experiences at the moment and which he wants to express in words. In their language there is an absence of generic words which signify

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Karon and VandenBos (1981: 54-55) explain here:

"A typical item used to measure concrete thinking is the ball and field test. A circle is drawn on a piece of paper and the patient is asked, "You have lost a ball in here. How would you go about finding it?"

"I have not lost a ball," is a response that is uniformly classified as "concrete." It is easy to confirm that this response occurs more often with schizophrenic people or brain-damaged patients than with normal individuals. Thus, one of our paranoid-schizophrenic patients would give such a response. Not only would he say, "I have not lost a ball," he would scream it and put his hands over his genitals.

This man was not lacking in the ability to form an abstraction, rather the examiner had raised a terrifying issue of life and death significance for the patient. He had to be concerned with that issue rather than with the task that the examiner thought he was setting for him. In other contexts, this particular patient handled abstractions very well, was very fond of philosophy, and was generally better able to manipulate abstract ideas than most people who had attempted to treat him. In fact, he confided in therapy, "I like abstract ideas, but I am not too much concerned about their empirical referents." In short, he used abstraction for defensive purposes."

> categories or classes. Or, when they do use such words, analysis shows that for the patient they do not correspond to generalizations. (p. 25)
>
> ...According to the specific way in which the patient experiences a certain object or situation, a definite property or aspect of the object or situation becomes the basis for the choice of words. (p. 26)

As Goldstein points out, if we key in to the concrete aspects of the immediate situation which is commanding their attention, we can understand the schizophrenics' references; e.g., one hospitalized schizophrenic called his physician "le dance," because the interns skipped around him during rounds (Goldstein 1944: 27). Similarly, many of their other terms are comparably easy to interpret, if we just pay attention to what they are experiencing.

It appears, then, that we ***can*** understand even schizophrenics and children[369] if we apply some effort. Admittedly, it can be quite a strain to try to keep up with schizophrenics, even if you know them well, as Cameron noted, but it's certainly not impossible. Thus, the proper conclusion to draw seems to be that the intentional method of understanding people is not so parochial as to be wanting. The next point to consider, however, is the extent to which it may nevertheless be an ***unreliable*** means: are intentional ascriptions too vague, ambiguous, or sloppy for psychology's purposes?

On the Vagueness and Observer Relativity of Intentional Ascriptions

A scientific practice has to be tailored to the domain it studies: just as it is inappropriate to measure trees that are to rough-hewn into rafts with the precision of a micrometer, so, too, is it inappropriate to criticize social scientists on the grounds that they only come to understand people once they have learned their language and acquired a similar conceptual framework, for that's how people are best understood – or so I've been arguing. Stich, however, complains that the intentional method of understanding is especially prone to *vagueness*, since it involves the investigator in a similarity judgment involving several fuzzy criteria which can come into conflict, making the range of content-based generalizations' application unclear.[370]

In reply, I grant that intentional reports *do* vary, both with the investigator and the audience, but I submit that this is a highly *desirable* characteristic, not a regrettable one. Any yearnings psychological investigators may have for effective operational procedures for determining the salient aspects of someone's cognition are misplaced, however, for we are extremely complicated systems with a great many individual differences, and it would be unreasonable to expect

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[369] Again, concerning the similarities in cognition between schizophrenics (who in some sense regress to earlier forms of thinking) and children, it should be noted that although there are child-like qualities to schizophrenics, their cognition is different. E.g., in comparing children, senile people, and schizophrenics on their problem-solving ability, Cameron *et al*. found "...the disorganized thinking of our schizophrenics followed neither the pattern of a common deterioration nor that of the normal child...the child is in the process of developing adult social language and thought organization, whereas the schizophrenic is in the process of losing it. But one process is not, as [is] often erroneously implied, simply the reverse of the other." (Cameron 1944, p. 59)

[370] E.g., Stich (1982); or Stich (1983), e.g., p. 136: "...as I was at pains to show in chapter 5, there is an appeal to *similarity* embedded in commonsense ascriptions of content. As a result, predicates of the form 'believes that p' are both *vague* and *context sensitive*, rather like such predicates as 'looks like Abraham Lincoln'."

psychology to adhere to standards that don't even apply in many other sciences.[371] So if psychology's interpretive judgments require interpretation, so be it; there are judgment-calls in any science's categorization, including syntactic mappings, as we saw in Section 4.3.2.1. The goal of explanations in general is to inform people of something, but since they can only be informative if they are understood, they must be delivered in a language the audience knows how to interpret – and that includes even syntactic reports (which must be decoded to understand that the meaning of the symbols in the report *is* their function). Because translations are very informative about the similarities in cognition underlying people's disparate languages, social sciences have very good reasons for using them, since the whole point of "making sense" of someone is to translate his or her thoughts and words into terms that can be understood.

Stich, however, argues that folk psychological reports vary in ways that frequently do *not* preserve the same salient content in translation, because they are riddled with conflicting criteria. Building on "Twin-Earth" intuitions, Stich tries to leave the impression that content attributions are pulled in quite different directions, and that it would be impossible to successfully disentangle them without switching to the syntactic theory. According to the analysis Stich (1982; and 1983, Ch. 5) calls the "Content Theory of Belief," there are three conflicting criteria implicit within the folk psychological practice of attributing intentional content to someone's psychological state, which appeal to (i) the causal interactions the state has to sensory stimuli and to behavior; (ii) the subject's ideological similarity to the subject; and (iii) the external referential history of the linguistic items associated with the state. Citing cases which illustrate how these criteria can pull apart, Stich (1983, p. 158) invites us to switch to an STM theory, on the grounds that "by eliminating the appeal to various dimensions of *similarity* much of the vagueness that plagues content-based cognitive theories is eliminated as well." In response, I shall urge that the last criteria he proposes in his "Content Theory of Belief" doesn't properly belong within individual clinical psychology, which reduces the potential conflicts considerably, while any remaining potential conflicts between the first two criteria are easily resolved in clinical practice.

Let's start with reference. As I argued in Chapters Two and Three, an appeal to "wide" considerations such as the causal or social history of a term a subject uses to express his or her thoughts is inappropriate to individual clinical psychology's explanatory task, since the external causal history of the words someone uses are too "baroque and recherché,"[372] too removed from the source of the action to serve as satisfactory *explananda*; instead, individual psychology

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[371] Gordon Allport (1968, pp. 290-91) gives an eminently sensible reply to operationalists in his *The Person in Psychology* when discussing criticisms of William Stern's personalistic psychology (which Reber [1985, p. 533 defines as, "The orientation that argues that psychological principles only have meaning when they are mapped into or shown to be reflections of personal life and personal experience"):

"To an operationist, of course, it is scientifically meaningless to have a coherent view of the psychological universe, or of any other universe. One should view only such portions of it as other people may agree with him about. Hence personalistics will be regarded as solipsistic – a *Weltanschauung* of one man only. ...a number of the personalistic categories (e.g. those of feeling) inevitably rest upon the evidence of immediate experience. As such they become operationally weak. Then there is the conceptual unification of the system as a whole for operationism to scorn. When this point is reached, I suspect the author might have to reply "so much the worse for operationism. There are tasks of synthesis for science more significant than the piddling regress of operationism. If mine is a solipsistic view of life, so too are all *Weltanschauung* and whether they get agreement or not, psychologists, like all other philosophers, cannot and will not live without them."

[372] See Godfrey-Smith (1986).

should appeal to the states which supervene on the subject's physical states which were actually in a position to produce the purposive behavior in question. As it happens, however, many of Stich's own cases which were intended to embarrass intentional psychology into saying that there is often "no comfortable way of saying" what someone believes (because intuitions are tugged in different directions) illustrate why reference similarity is not a psychologically relevant dimension of belief, so let's turn to them.

To start with, Stich presents two down-to-Earth Twin Earth examples. The first concerns chicory and endive, whose names are reversed in America with respect to the labels the plants receive in Britain; when subjects who have no first-hand experience of either plant utter "Chicory is bitter," we may be inclined to attribute different contents and truth-values to their professed attitudes, depending upon their nationality, despite the underlying similarities in their individual psychologies (see Stich 1983, pp. 63-64). A second example has us consider two men who utter "Ike is a politician who likes to play golf": one is a Victorian Englishman whose contemporary is 'Ike' Angell-James, while the other is a contemporary American who has heard dimly of Dwight 'Ike' Eisenhower; both subjects, however, are completely ignorant of any further facts regarding the bearer of the name they use, and so there may be some ambiguity about whether or not they have the same belief (see Stich 1983, pp. 60 ff., 95).

As I argued in Part I in response to these sorts of cases, the alleged ambiguity quickly resolves itself when we keep the object of inquiry fixed. Depending upon whether we want to understand why the individuals actually behave as they do, or whether we simply want to take their words at face value by giving a conventional interpretation to what they say, we will favor different readings of their utterances: the *psychological* and the *social*, respectively. For the latter purpose, we count the American and British subjects as making different statements (about different vegetables or politicians), but for the purpose of understanding their actions, we should "bracket off" external facts which the subjects are unaware of and count them as having the same beliefs, insofar as their impoverished internal conceptions of their referents are identical and would lead them to behave the same in similar circumstances. Granted, we may have to coin a new term to capture the content of these subjects' thoughts (such as "chive," or, since that's taken, "endory"), but it would be a mistake to claim that they actually have beliefs about chicory or endive or Angell-James or Eisenhower, since by hypothesis they don't have enough identifying knowledge about them to pick them out from other sorts of vegetables or politicians. The lesson of Stich's examples (including a third one which concerns an immigrant confused about who "Jefferson" is[373]) about the alleged conflict between referential and ideological criteria for ascribing content thus seems to be that we mustn't conflate the questions, "What is someone thinking?" and "What is he thinking ***of***?" and instead of showing that intentional psychology's attributions are a mess, they show that we have to get straight on what the question is as we proceed with an investigation.

[373] The inappropriateness of appealing to referential considerations to understand someone's reasons is underscored by a third example Stich (1983, p. 145) raises, which concerns Binh, a confused refugee who confounds (Thomas) Jefferson the President with *The Jefferson's* dry-cleaning TV character, and a logician named Feferman. When Binh states, "I am very anxious to learn more about this fascinating fellow Jefferson, the black patriot and statesman who made significant contributions to logic while building a dry cleaning empire," Stich (1983, p. 146) asks, "what content shall we use to characterize his belief?" However, there is no problem here: Binh simply believes that there is someone named "Jefferson" who is a black ex-President who owns some dry-cleaning outlets and does logic. Of course, there is no such person and so he's not strictly *referring* to anybody, but that surely doesn't stop him from thinking that he is.

Once we factor out reference, this brings us to the first two criteria – which involve the surrounding network of beliefs mental sentences are embedded within, and the pattern of "potential causal interaction with (actual or possible) stimuli, with other (actual or possible) mental states, and with (actual or possible) behavior" (Stich 1983, p. 89), respectively. The notional content involved in notional or phenomenal world psychology does incorporate not only abstract, formal, or theoretical ideas, but also sensory content, since both go into someone's phenomenal world.[374] Obviously, however, Stich's point about the potential for conflicts still stands even after eliminating referential considerations to the frame of intentional explanations, so long as more than one independent criterion for content attribution remain, so let's take a look at how serious a problem this is.

One example Stich (1983, pp. 70-71) raises in order to show the tension between the first and second criteria for content attribution concerns a certain sort of schizophrenic, whose peculiar inferential patterns led from the belief that Napoleon was a great leader plus the conviction that he is a great leader to the conclusion that he is Napoleon; since the individual in question infers differently than we do, are we prepared to say that he has the same belief *we* would have, if we were to sincerely utter, "I am Napoleon"? As Stich (1983, p. 71) puts it, "To my intuition, the answer is neither clearly yes nor clearly no. The example of inferential breakdown seems to suggest that our intuitions are guided by the degree of causal similarity between a subject's belief and our own."

However, although inferential patterns *sometimes* determine the content of thought (especially in such "meaning is use" cases as learning arithmetic[375]), in this case, the relevant factor in determining the content of the schizophrenic's belief isn't his overinclusive logic, it's whether he has any real conception of who Napoleon is. People with delusions of grandeur aren't driven by their *logic* nearly so much as by their *desire* (or need) to be someone great and wonderful to compensate for how awful they feel about themselves. But just *who* someone thinks he is when he says "I am ***X***" depends on how he backs the name, so Stich is right to say that the answer to whether this subject believes he is *Napoleon* is "neither clearly yes nor clearly no," but not for the right reason. The reason is, we're not given enough information about the person's notional world; whether it's a ***Napoleon*** delusion depends on how rich his "Napoleon" conception is, and how well it accords with the historical character. Most (American) people, schizophrenics included, only know that he was some great French general who kept his hand in his vest; their content isn't much richer than thinking that they are some great man who is *named* "Napoleon." But contrast their sense or mode of presentation backing the name to, e.g., Zeno Vendler's, or an

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[374] E.g., a notional world psychotherapist such as Berger (1984, p. 113) point out that the therapist has to recreate that world in his own imagination, as we do when reading a book or seeing a movie, and sensory information is important, too:

" ...in literature, the author invites the therapist into the separate and imaginative world of the novel...in the psychotherapeutic situation, the patient invites the therapist into the patient's separate world. As with the novel, the patient's world is filled with imagery and atmosphere, with sights and sounds, and with a multitude of characters...[but the idea of a film might provide a more suitable analogy because it may transmit more accurately attitudes and emotions from archaic and preverbal periods of development. Whatever metaphor is chosen the emphasis is on the therapist's need to transport himself into another world, a world that requires the use of the senses."

[375] As we saw in Section 5.1.2.3, Stich (1983, pp. 143-44) raises the case of learning arithmetic as a difficulty for the Protagorean, content-level way of understanding children's cognition.

historian's, or a professional actor who becomes stuck "in character".[376] The content of people's delusions depends on what identifications they have made in defining who they think they are, not on whatever name they happen to use.

In another series of examples, Stich (1983, 66 ff.) points out that causal and ideological similarities can pull apart in cases of "irrelevant causal differences" such as color-blindness. These examples raise thorny philosophical questions about the relative importance of concrete sensations and abstract ideas in meaning. Nearly everyone would grant that someone who has never had occasion to see *vermillion*, say, would still have pretty much the same concept of color that we have, and we may even allow that people who are red- or green-blind do, as well, although they have different qualitative associations. However, when they are totally deprived of the sense modality altogether, it's quite a different kettle of (notional) fish: Helen Keller must have had a quite different conception of what the world was like than the rest of us. Obviously, a gradation is involved here in the relative importance of subjects' sensory differences in determining the content of their beliefs, one which depends not only on the amount of information they lack, but also on how relevant that information is to the behavior to be explained. Judgments do have to be made, but since the relevant contextual factors are supplied in the clinical setting, there is no difficulty in practice in determining the relative importance of causal and ideological similarity. Stich's own examples bear this out: because blind people have other ways of interacting with cats, we acknowledge that they have a pretty good idea what cats are, and so we wouldn't bother to attribute a different sort of feline concept to them (e.g., 'invisible-furry-purrers') which takes their perceptual deficits into account to explain why they got up to answer the scratch at the door (cf. Stich 1983, pp. 66-67). But if the question is, "Why in God's name did Peter throw the green switch when he ought to have pulled the red one?" the fact that he perceived it as being red due to his color-blindness *is* crucial (cf. Stich 1983, p. 68). Since such context-sensitive judgments are easily made in the course of clinical investigations, I submit that they represent no major obstacle or source of unreliabilty for intentional psychology.

But even if ambiguity is not a problem for folk psychology, is vagueness? Does the fact that psychological investigators engage in *similarity* judgments suggest that there is no determinate phenomena being investigated? Before dismissing Stich's "Content Theory of Belief" and its implications for intentional psychology completely, we should note that Stich himself undercuts the force of his complaint against psychology's vagueness when he acknowledges that many types of judgment about objects and processes in the world admit of degrees, especially those using concepts involving ***prototypes*** or ***exemplars***, rather than a set list of necessary and sufficient features.[377] Categories and classifications almost always involve gray areas, but

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[376] As an exercise illustrating "transference," Vendler (1984, pp. 34-35) shows he *is* able to imagine himself to be Napoleon, because he knows enough about him to do so. Unless he is a history buff, the schizophrenic, however, is unlikely to, so we should probably put his references to his belief that he is 'Napoleon' in scare-quotes. However, after a certain point we'd be perfectly willing to ascribe to Sylvester Stallone (who, after all, has probably never killed anyone in his life) the belief that he <u>is</u> Rambo, since he knows so much about the character and may sometimes act the part.

[377] Concerning the metaphysics of belief, Stich (1983, p. 91) concedes that we cannot judge from the fact that we are making a similarity claim that there is no underlying fact of the matter about the phenomena we are judging to be similar. Stich notes that categories such as "cup" involve us in similarity judgments which admit of degrees ['Methinks it is very like a cup, but it lacks a proper handle...' yet that hardly shows there are no cups. If "prototype" views of concepts are correct (see, e.g., Stich (1983) pp. 86-87), then <u>all</u> categorial judgments may be similarity judgments, but that doesn't mean that no categories refer.

clearly, not all judgments applying them are equally valid: some dishes (e.g., flat disks) are not cups, and some investigators' attributions of content are dead wrong; then again, some dishes *are* cups, and many attributions are spot on. Stich (1983, p. 92) concedes as much when he discusses an expert examining a forgery and grants that, "while the sentence ***type*** "A is similar to B' may be quite vague, individual tokens uttered in context can be very recise [sic][378] indeed," and he comes very close to admitting just what's at issue, namely, that *de dicto* ascriptions by co-linguists paying particular attention to word choice can be quite precise as well.

The plot thickens further when Stich tries to placate those who object to the eliminative materialist's suggestion that historical explanations imputing motives and intentions to people are of a piece with the claims of witchcraft or medicine men. Stich's response gives the intentionalist back the farm: he grants that Henry VIII may very well have had the belief-like states historians have attributed to him, and he says, "Even the vagueness of belief sentences need not be much of a problem to the historian, since it is generally reduced by context. And historians have context to spare" (1983, p. 227). If having "context to spare" is enough to acquit the historian of the mumbo-jumbo charge eliminativists like to make,[379] then this goes doubly for the clinical psychologist. As I shall now argue, clinical investigations *are* rich in context, and these contexts facilitate the confirmation of the investigators empathic judgments.

Confirming Intentional Ascriptions

As we have seen, folk psychological therapists proceeds by interpreting their clients' symptoms and mind-set. However, a familiar difficulty of this approach is known in philosophy as "The Problem of Other Minds," and it is a problem of verification: what counts as getting it right, and how could we know if we have? As I shall now explain, Freud and other clinicians have several responses to this problem. A correct interpretation, in their view, is one which reconstructs the subjects' notional world, including the pathological unconscious influences they are unaware of. Evidence for the truth of an investigator's interpretation is to be found in the patient's behavior in the course of the therapeutic relationship: the subjects themselves can explicitly corroborate the accuracy of the intentional attributions; and when the therapists successfully confront them with their interpretations (thus "making conscious what was pathologically unconscious") and the patients' symptoms are cured, the cure itself confirms the attributions regarding the unconscious material.

Following Freud's suggestions, some philosophers such as Marcia Cavell have submitted that the success (in terms of dispelling the unwanted symptoms) of a therapist's interpretation of the conscious or unconscious reasons behind someone's psychological problems is *constitutive* of the

[378] This typo serves to illustrate the point to be developed in the next paragraphs, that the context the intentional psychologist works in usually suffices to disambiguate references, since the context indicates that he means "precise."

[379] For eliminativists' disparaging references to witches or demons, see not only Stich (1983) and Churchland (1981), but also their predecessors' articles reprinted in David Rosenthal's *Materialism and the Mind-Body Problem*: Paul Feyerabend, "Mental Events and the Brain" (1963), and Richard Rorty, "Mind-Body Identity, Privacy, and Categories" (1965), and "In Defense of Eliminative Materialism" (1970).

truth of the analysis.[380] However, for obvious reasons, I don't want to make the strong claim that such "cures" constitute *conclusive* proof of the authenticity of the interpretation, since the patient might have changed his attitudes either quite independently of the influence of the therapist's remarks, or due to the sheer power of *suggestion*, even though the therapist didn't really understand his actual problem at all. Then again, the fact that a condition clears up after an antibiotic is administered doesn't *prove* the correctness of a doctor's diagnosis that it was a bacterial infection, either, but it does provide *supporting* (albeit inconclusive) evidence.

However, we needn't focus solely upon the final outcome of successful therapy, since there is plenty of opportunity for confirmation of content attributions along the way within the clinical interviews themselves. As their very name indicates, clinical inter-views are quite unlike interpretive activities such as reading historical texts in the following respect. Unlike books, the subjects being interpreted don't take a purely passive role – they are alive, face-to-face with their investigator, and able to provide feedback about how appropriate the attributions are. Moreover, although clinicians are like historians in that they can investigate their subjects' cultural and educational background, they have a considerable advantage over historians, in that they can also confer with them to disambiguate their attributions. As a result, the investigators can not only solicit confirmation from their clients concerning their interpretations, but the subjects often also take it upon themselves to contest and correct the therapist's attributions. This two-way process is the whole point of the activity known as the "reflection of the client's feelings," which is involved in accurate empathy, the most fundamental facet of psychotherapy; as Bernstein and Neitzel (1987, pp. 298-99) point out, reflection "serves the dual purpose of (1) communicating the therapist's desire for emotional understanding and (2) making clients more aware of their own feelings." When the therapists' paraphrase of what they seem to be hearing is way off base, the clients will frequently let them know in no uncertain terms, "You don't know me, you don't know me at all," and then do their best to set them straight. People, especially psychologically disturbed people, are very sensitive to whether they've really been understood or if the clinician is just faking it and just trying to get on with it and rush them out. Although some are suggestible, in general the clients will perceive the therapist as understanding them only if he does in fact understand "where they are coming from," and their feedback will help the therapists arrive at more accurate understandings of their attitudes.

Thus, there is an empirical check on what could otherwise be a completely ungoverned process wherein therapists projected their own thoughts onto others, and once again, clinical psychology has "context to spare," so the fact that intentional attributions are context-sensitive does not impugn their precision or veridicality. As I hope to have shown, then, clinical psychology's method of projective understanding is neither impossibly riddled with conflicting criteria, nor doomed to sloppiness and failure, nor overly limited in its scope of application, so it *does* seem suited to the needs of the applied science of psychology.

[380] E.g., the philosopher Marcia Cavell gave a colloquium paper on the topic of cures confirming interpretations at UCSD in 1986.

Chapter 6

Introduction: NeuroEliminativism versus "Folk" Psychology

As the chief contemporary spokesmen for Eliminative-Materialism (E-M), the Churchlands are not primarily concerned with whether psychology's explanatory posits need to be narrow or wide (although they have spoken in favor of narrow psychology in principle, in their [1983]). Instead, they openly question the veracity and utility of the theories and services of "primitive," "folk" psychology, and they submit that eventually ("Maybe not today, or tomorrow, but *soon*" – or else this would just be an academic debate, which is hardly what the pragmatically-inclined eliminativists intend @note[time-frame]) the intentional approach will be completely superseded in scientific contexts by a vastly superior paradigm which affords a deeper understanding of human beings and a greater facility to change behavior. Not to mince words, Churchland (1988, p. 45, his emphasis), for example, declares that eliminative materialists regard our common-sense psychological framework as "***a false and radically misleading conception of the causes of human behavior and the nature of cognitive activity***...an outright ***mis***representation of our internal states and activities," and he adds in his (1981, p. 67) that it is "so fundamentally defective" that both its principles and its ontology will eventually be displaced. And as ***neuro***eliminativists, they aren't just offering an idle speculation that some new wonder science may arise – in works such as ***Matter and Consciousness*** (1988) and ***Neurophilosophy*** (1986), they not only take the offense by alleging that folk psychology is both mistaken about the causes of our behavior and inadequate to deal with it effectively (particularly when it comes to *abnormal* psychology and "the major forms of mental illness," where it's arguably needed most), @note[major forms] but they also champion neuropsychology as the most likely candidate to succeed it. @note[prognosticates] E.g., Paul Churchland (1988, p. 146) provides a warm testimonial on behalf of neuropsychology's theories and practices, which apparently show considerable promise of being able to some day ***eliminate*** both the "folk" psychological paradigm *and* mental illnesses "outright," judging by the "qualified" success of the main treatments of its subdiscipline, psychopharmacology. @note{Imipramine}

Thus, rather than simply harboring or expressing mistaken views about the nature, methods, or purposes of intentional or clinical psychology (as the wide and syntactic philosophers seem to), the neuroeliminativists are actively furthering the interests of its chief rival, neuropsychiatry, in the often acute competition for resources and legitimacy. Consequently, of the philosophical opponents to narrow intentional psychology, they are actually the most formidable threat, insofar as they advocate means of mental health intervention which have the very real potential to cause serious harm, as I'll explain in Chapter Seven (and a forthcoming project concerning psychoses). But first, since neuroeliminativism isn't simply based on the claim that mental illnesses will eventually be cured by neuropsychiatry, of course, I'll begin by reviewing and responding to some of the independent and somewhat more theoretical or "philosophical" arguments in its favor, as well, again concentrating mainly upon P.M. Churchland's work.

Churchland mounts three main assaults on the fundamental integrity of folk psychology (FP), which I'll be calling the "Limitations" argument, the "Irreducibility" argument, and the

"Historical" argument, respectively. As we'll see, the last of these is a broad historical argument which concludes on the basis of an assessment of intentional psychology as a "stagnant" research paradigm that belief-desire explanations will be swept away in the march of scientific progress and "go the way of the Stoic pneumata, the alchemical essences, phlogiston, caloric, and the luminiferous aether" (Churchland 1979, p. 114). The second main battery supports the same conclusion with a combination of empirical and *a priori* assumptions and claims about the possibility and importance of a theory's being ***reducible*** to the more basic physical sciences, and the final barrage focuses on intentional psychology's other alleged explanatory deficiencies, besides its problems in coping with mental illnesses.

As Churchland notes, these allegations and arguments in support of eliminativism can achieve the most force when used in combination, but my strategy in response, of course, is to divide and (attempt to) conquer or defuse each one in turn. I'll take them in reverse order, proceeding quickly through the allegations about intentional psychology's explanatory limitations and limited prospects for reduction, in order to spend the most time on Churchland's repeated charge that "FP" is a "stagnant" paradigm which "has enjoyed no significant changes or advances in well over 2,000 years, despite its manifest failures" (1988, p. 46).

The Limitations Argument

In brief, the Churchlands' "Limitations" argument draws attention to the fact that the common-sense intentional theory is a ***limited*** approach that doesn't explain everything of interest to psychology, and urges us to try to replace it with something more comprehensive. In reply, I shall be arguing that it is indeed a specialized theory, but it's not so limited that we should want to be rid of it on that account.

Since the logical first step to showing that something is a *limited* theory ripe for elimination is to show that it's a ***theory***, in a series of works Churchland has sketched some of the basic law-like relations, generalizations, and common-sense homilies (such as "Persons in pain tend to want to relieve that pain" [1979, p. 92]) of the theoretical framework implicit in the paradigm he has variously called "Rational-Agency" psychology (1970), the "**P**-theory" or "Person-theory of humans (1979)," and, of course, "FP" or "folk" psychology (see his 1981, 1988 or 1988b). The intentional explanations afforded by this approach, as we've seen, impute *reasons* to people – wishes, beliefs, expectations, desires, and sundry other such *attitudes*, or meaningful psychological states that have some sort of intentional *content* – to make sense of why they behave as they do. But as Churchland emphasizes in a number of places, while this approach may have some success in explaining everyday behavior (e.g., such as when people are hostile to those they think have designs on their loved-ones or property) it clearly doesn't explain ***everything***.

Since only he can truly do justice to his position, however, let's hear Churchland's indictments against intentional psychology in his own words. To start with, Churchland (1979, p. 114) argues that our confidence in intentional psychology isn't justified, because once we recognize its theoretical or hypothetical status and gauge its merit ***as*** a theory with explanatory applications, we'll find that it falls short:

> There is only one place to look for justification, and a measure can indeed be found in [its] actual success...as the vehicle of our mutual understanding. But it is just here that the case [for FP] is so problematic, if one looks at all closely, for its success is in many respects radically incomplete. Its comprehension both of practical and of factual reasoning is sketchy at best; the kinematics and dynamics of emotions it provides is vague and superficial; the vicissitudes of perception and perceptual illusion are, in its terms, largely mysterious; its comprehension of the learning process is extraordinarily thin; and its grasp of the nature and causes of mental illness is almost nil.

Along the same vein, Churchland (1981, p. 73) writes,

> Consider our utter ignorance of the nature and psychological functions of sleep, that curious state in which a third of one's life is spent. Reflect on the common ability to catch an outfield fly ball on the run, or hit a moving car with a snowball. Consider the internal construction of a 3-D visual image from subtle differences in the 2-D array of stimulations in our respective retinas. Consider the rich variety of perceptual illusions, visual and otherwise....Of these and many other mental phenomena, FP sheds negligible light.

These charges about intentional psychology's explanatory "impotence" and its "primitive" and "superficial" nature (Churchland 1979, p. 115) are serious allegations, because by questioning its practical virtue, they impugn this applied science right where it counts the most. Because I regard the charge about its (in)ability to cope with or "cure" (see Churchland 1988, p. 46) mental "illnesses" very seriously, indeed, I shall be devoting the whole of Chapter Seven to that issue, but in this Section, I shall address folk psychology's other alleged deficiencies. My strategy is to divide the alleged problem into two issues: i) is the claim that there aren't good cognitive understandings of phenomena such as illusions and "tricks" of the memory even ***true***? and ii) what, if anything, does it imply about intentional psychology's validity even if it is? Let's start with the second matter.

Not My Job

Although I grant (*pace* some philosophers, such as Wilkes @note[theory]) that intentional psychology ***is*** a theory, and that ultimately it is a limited theory (since it doesn't explain everything or help us with every problem), nevertheless, I submit that the complaint that intentional explanations are limited in their scope of application is ably met by the retort made famous by the late Freddy Prinze: "Eez not my job!"

In other words – those of Horgan and Woodward (1985) – intentional psychology shouldn't be ***expected*** to explain all the matters our pre-theoretical intuitions group together as "psychological," and Churchland is probably placing an unreasonable *a priori* demand on a specialized empirical science when he claims that it should. @note[Horgan]

Similarly, Ausonio Marras (1985, p. 298) defends narrow computational psychology @note[(cognitive)] against the Churchlands' (1983) complaints about psychology's limitations in much the same fashion, submitting that psychologists who advert to internal representations to explain a certain class of phenomena and range of behavior (namely, purposive behavior) can "cheerfully admit" the need for adjacent disciplines such as psychobiology to explain such things as how those representations are produced in the brain in the first place, but that does nothing to take away from the importance of recognizing and understanding people at the intentional level. @note[Kosslyn] The moral of these considerations about early vision and the like, as Marras (1985, p. 297) urges, is that a discipline should not be faulted for not doing what it was never

intended or expected to do (so long as it does what it does well, it should be added, an issue I'll be pursuing in detail in the subsequent chapter) and that the message seems "to be one of tentative rapprochement, peaceful coexistence, even cooperation" (p. 298), instead.

Likewise, even Churchland (1981, p. 74) himself confesses that the fact that FP sheds little light on phenomena such as how we learn doesn't in itself impugn its claims to truth; although he goes on to comment,

> Failures on such a large scale do not (yet) show that FP is a false theory, but they do move that prospect well into the range of real possibility, and they do show decisively that FP is *at best* a highly superficial theory, a partial and unpenetrating gloss on a deeper and more complex reality. Having reached this opinion, we may be forgiven for exploring the possibility that FP provides a positively misleading sketch of our internal kinematics and dynamics, one whose success is owed more to selective application and forced interpretation on our part than to genuine theoretical insight on FP's part.

However, because the neuroeliminativist inference betrays a fundamental lack of understanding about the nature of specialized sciences, I submit that they should not be forgiven for making their pessimistic analysis. Allow me to explain, with the use of a common-sense analogy to automechanics.

There are many penetrating mysteries about all the wondrous materials that go into making cars that your garage mechanic probably won't be able to tell you a good deal about (such as, what ionic changes go into producing rust, or how to forge cast-iron blocks, or what the precise gas-pressure laws are, etc.), and many things that he can't fix, either, but that doesn't mean that his "highly superficial" diagnoses of your cars' problems aren't deadly accurate, nevertheless, as when he says, "You've cracked your block and lost compression, and won't be able to drive over 10 m.p.h." Of course, in this particular case, there's nothing much the mechanic can do to help directly (just as the intentional psychologist is often helpless when confronted with massive brain damage) but with his crude explanatory posits such as "engine blocks" (which are hardly natural kinds, and can be realized in a number of different materials: iron, aluminum, maybe eventually polymers) he has diagnosed the problem and saved you from futile attempts to fix it by replacing other parts. More importantly, in a wide variety of other cases, he can not only diagnose and explain your problem, but also solve it. Some topics, of course, may be quite beyond his realm (such as explaining how nuclear reactors work, or how sub-atomic particles form bonds), and the power mechanics he was taught in trade school may not be a comprehensive theory that reduces smoothly to unified field theory, but it would be unthinkable or obtuse to discharge his services on that account, since in many cases he provides an affordable degree of control over the matters he ***can*** help us with, and he can get us off and running again. The moral of the tale is, as long as an applied science ***is*** useful – as long as it ***does*** understand and control the phenomena it does address to a satisfactory degree – there is no reason to abandon it; so, contrary to the reductionists' predictions or predilections, we'll probably keep both auto mechanics and psychologists around as long as there *are* people and cars, barring disaster. ***None*** of the applied sciences are universal in scope and can fix or explain everything (your mechanic may find himself baffled by both an original Model 'A' and by the "Moonmobile," but that doesn't prevent him from doing a bang-up job with your new Rabbit), and there's plenty of work for us all to do. If you want to know the precise *laws* governing the compression of gas for some reason, call a theoretical physicist – but don't try to get him to rebuild your transmission: he's probably just as helpless as the rest of us when it comes to solving immediate practical problems.

So even though it's true that psychology doesn't explain everything, and even if it "sheds negligible light" on the phenomena mentioned, there is still plenty of room and work for both the more specialized applied sciences and the more basic theoretical sciences. However, since I don't want to be *too* conciliatory here, considering the particular shortcomings being adduced, let's go on to consider whether it's even true that intentional psychology has no insights to offer into the areas of vision or memory (not to mention psychopathology and mental illness).

Further Applications of the Intentional Approach Although intentional psychology, like any other science, makes no pretense of being able to understand and control *every* matter, and although it's not in the business of explaining how brains work at the level of the "wetware," in fact it does have some things to say and do about some of the intentional phenomena Churchland maintains it sheds negligible light on.

A number of observers have commented on the unfoundedness of Churchland's allegation, because a good deal of recent and ongoing work in cognitive and experimental psychology has utilized the theoretical apparatus of intentional psychology to explain memory, perception, and other matters. E.g., writing "In Defense of Intentional Psychology," Patricia Kitcher (1984, p. 91) submits that Churchland's examples are "ill chosen to make his point," because both memory and 3-D perception have been illuminated by the work of the intentional psychologists she notes. @note[3-d] Similarly, in their "Folk Psychology is Here to Stay," Horgan and Woodward (1985, pp. 200, 298) comment,

> ...while FP itself may have little to say about the matters Churchland mentions, theories based on concepts deriving from FP have a good deal to say about them. For example, cognitive psychologists have developed extensive and detailed theories about visual perception, memory, and learning that employ concepts recognizably like the folk-psychological concepts of belief, desire, judgment, etc....For visual perception, see, e.g., Gregory [*The Intelligent Eye*, New York: McGraw-Hill, 1970]. ...The versions of attribution theory and cognitive dissonance theory [of Nisbett and Ross 1980, e.g.]...are [also] important cases of this kind...[they] give center stage to folk-psychological notions like desire and belief.

Of course, it would take me too long and too far afield to get into the details of the works that were mentioned (though recall the discussion of some of Nisbett and Ross's work in Part II) to illustrate how they illuminate the phenomena they study using intentional notions, so I'll just echo Horgan and Woodward's (1985, p. 200) conclusion to this strain in Churchland's argument: "That all such theories are unexplanatory is most implausible, and in any case requires detailed empirical argument of a sort Churchland does not provide." Similarly, some of these phenomena have been illuminated from the clinical side. Just as we often lie to ourselves in the present by seeing just what we want to see, our memories play tricks on us in certain systematic ways, depending upon what we want or need to believe about ourselves, and what we have been through.

But what about the limitations of the intentional approach in dealing with serious abnormalities? E.g., in his (1988, p. 46) indictment of FP's explanatory power, Churchland continues,

> ...So long as one sticks to normal brains, the poverty of folk psychology is perhaps not strikingly evident. But as soon as one examines the many perplexing behavioral and cognitive deficits suffered by people with *damaged* brains, one's descriptive and explanatory resources start to claw the air. ...As

> with other humble theories asked to operate successfully in unexplored regions of their old domain...the descriptive and explanatory inadequacies of folk psychology become starkly evident.

However, just as we shouldn't expect computer programmers to be of much help with glitches which arise from water-damaged circuits, there's no particular reason to ***expect*** psychologists to be of help in cases of demonstrably ***organic*** damage – it's a job for neurobiologists, if anyone. Ironically, however, the tables are turned once again, because although both approaches are reduced to accounting for such people's performances in terms of deficits and breakdowns in normal capacities, in many of these brain-damage cases it's *neuroscience* that can't do much of anything except "claw at the air" when it comes to doing anything constructive about them, while a little applied psychology can actually be of a lot more help in dealing with people with a wide variety of impairments. The main reason for this is that diseases such as Alzheimer's are degenerative, but neurons don't regenerate; similarly, although there may be some additional sprouting of surviving neurons in injured brains, they often lead to no substantial improvement and even to a decline in functioning, because the injuries develop scars, and irregular pathways are formed. @note{Sprouting} Thus, although it seems natural to assume that *organic* problems require some sort of organic or somatic medical treatment (as the Churchlands seem to be implying), this is clearly not always the case, since some demonstrably organic problems may nevertheless benefit from a psychological approach, while failing to yield to somatic treatments at all.

Consider, for example, Down's syndrome. Because it is sustained by such a pervasive and yet minute cause – the presence of an extra twenty-first chromosome in every cell of the body – it can't be ameliorated by drugs, because we can't eat away *just* the extra chromosomes without wiping out a good deal more of the person's vital functions. @note[Ruston] However, although we can't give them drugs to make them smarter (would that education were so simple), we *can* use psychology to help Down's children get a lot more out of their lives and become more involved in certain occupations, by taking them at their own level and giving them personal attention and special education, to help them make the most of what they've got. @note[Down's] And for another range of cases, I refer you to Oliver Sacks charming (1985) book, *The Man Who Mistook His Wife for a Hat*. Sacks, a clinical neurologist who is usually only called in to confirm that neurological damage has been done when it is too late for medicine to be of help, describes what a clinician such as himself ***can*** do to treat brain-damaged patients constructively: he can interact with them on a personal basis by discussing art and trying to engage them in practical activities, in order to help them develop their existing capabilities and increase their self-esteem. Sometimes he has to use intentional content and psychology even more explicitly, such as when he has to *convince* someone with hemi-neglect that the alien limb attached to him is indeed his own leg. @note[Sacks] And as far as cases such as Stich's senile housekeeper, Mrs. T (see Stich 1983, *passim*), clinical psychology can appraise their remaining capacities to alleviate their concerns, and help them to enhance their remaining abilities by teaching them mnemonics, e.g.. @note[mnemonics] And finally, clinicians have found that they not only need to use psychology to help neurological *patients* cope with or at least acknowledge their impairments, but they also have to know how to use some psychotherapy to help patients' ***families*** adjust to the disability or illness, as well, so that they don't aggravate it with their fussing or grief, and they can learn how to cope with living with someone who has no recollection of them or who asks them the same questions over and over. @note[amnesic] Most of the families and acquaintances involved could use the help of a counselor or therapist who can get them to realize that the damage is done, that

things will never be the same as they were, and that they must learn how to let go of their expectations of the patients' former selves and take them for what they are now. @note[realistic] Judging from many of the cases of brain-damage and retardation, then, clearly the class of organic conditions that benefit from psychological modes of treatment is not empty, and clinicians sometimes need to employ psychology to make the best of a bad situation. Thus, regardless of how it turns out for "the mental illnesses," psychology actually wins part of its "limitations" suit regarding psychopathology right here – it is probably always going to be needed to help in these cases, unless or until we can heal dead brain cells.

Even though the intentional approach has its limitations, then, it is not quite so limited as Churchland suggests; but even if it were, that is no reason to eliminate it, so long as it does some things well. Accordingly, let's proceed to his other charges, starting with the complaint that folk psychology seems unlikely to reduce to the more basic sciences.

Folk Psychology and Reduction

Having impugned folk psychology's explanatory powers and apparent prospects for advancement, Churchland gives it one more chance: perhaps it can survive as a scientific discipline yet, but only if its theoretical posits and laws are amenable to "integration with" and ultimately "*reduction*" to those of some more basic or naturalistic scientific theory. But it's just here, he remarks in his (1981, p. 75), that FP "fares poorest of all," because

> If we approach *homo sapiens* from the perspective of natural history and the physical sciences, we can tell a coherent story of his constitution, development, and behavioral capacities which encompasses particle physics, atomic and molecular theory, organic chemistry, evolutionary theory, biology, physiology, and materialistic neuroscience....[b]ut FP is no part of this growing synthesis. Its intentional categories stand magnificently alone, without visible prospect of reduction to that larger corpus. A successful reduction cannot be ruled out, in my view, but FP's explanatory impotence and long stagnation inspire little faith that its categories will find themselves neatly reflected in the framework of neuroscience. On the contrary, one is reminded of how alchemy must have looked as elemental chemistry was taking form, how Aristotelian cosmology must have looked as classical mechanics was being articulated, or how the vitalist conception of life must have looked as organic chemistry marched forward.

As before, Churchland's imputations of "FP"s failings fairly cry out for response, and my strategy once again is to split them into two separate issues, and reply to each one in turn: 'Is the allegation (that intentional psychology doesn't comport well with the other sciences) even *true*?' and, 'So what if it is?'

Are Intentional Categories Irreducible? To begin, then, we should consider what grounds there are for supposing that the categories of intentional psychology will fail to fit in with those of the other sciences. In one group of arguments (which Patricia Kitcher sums up nicely in the note @note[saltation]), the Churchlands focus upon the *sentential* approach of the intentional paradigm, which regards intentional states as sentence-like entities, which may seem to be at odds with how the rest of the animal kingdom operates. However, as Kitcher (1984, p. 98) points out, this range of arguments about the allegedly fatal implications of young children and non-linguistic animals for the sentential approach is essentially question-begging, since it "tacitly denies the position some of its key resources and then argues that it is unable to handle these cases. If intentional psychology is allowed to have its basic postulates, it is quite easy to

construct explanation-sketches for the alleged problem cases." Easy, that is, if we are willing to attribute both concepts and some sort of internal language of thought to children and animals, even in the absence of or prior to the acquisition of a spoken language, a not unreasonable assumption, given not only the fruit it bears, but also the standard evolutionary hypotheses about the specialization of the relevant underlying brain structures in humans, such as those presented by Ernst Mayr, as Kitcher goes on to note. Moreover, the Churchland's complaints about the alleged discontinuity between sententialism and neuroethology can probably be met by more contemporary evolutionary accounts such as Gould's "Punctuated Equilibrium" theory, anyway, which undermines their assumption that there must be continuous stages in evolution. @note[Gould] Besides, the intentional approach isn't necessarily wedded to the sentential model, so long as our attitudes about ourselves and the world are realized in some form or other, so all in all, we need to find some more convincing reason to think that intentional categories won't eventually be reduced by some more basic theory, apart from these appeals to evolutionary considerations.

One reason, of course, which I argued myself in Part II, is that the states of mind notional world psychology is concerned with can't be reduced to an exclusively *syntactic* account. But what about a richer alternative: perhaps a more *neuro*computational account can be more accommodating? Actually, the prospects of finding a powerful enough computational theory to serve as a theoretical foundation for intentional psychology appear to be a lot more promising now than they were five or ten years ago when these charges were made. Recent developments make it now seem that narrow content can indeed be incorporated into the so-called *connectionist* models such as Parallel Distributed Processing, *pace* the suggestions of Stich *et al*. (forthcoming). Before he left UCSD, David Rummelhart, recall, declared that he "believe[s] in representations," and no less an observer than Patricia Churchland (1986b, p. 250) herself has declared,

> ...neurobiology already has quite a lot to say about how in fact simple nervous systems represent; that is, how they have states that are about things....brains have evolved such that neurons are connected up in the right way – with each other, with the receptor sheets, and with the motor periphery. They are also rigged so that they can modify their connections.... connectionist models...are already available to illuminate very well the idea of representing by physical systems.

Similarly, connectionist approaches judiciously combined with more traditional or symbolic approaches are starting to show considerable promise of providing a computational account of internal representation; see, e.g., Andrew Clark (1989), or, somewhat ironically, P.M. Churchland's own ***Neurocomputation*** (1990). So once again, it may be sooner than we think before a richer account is developed within cognitive neurocomputational science that can accommodate the kind of semantics intentional psychology trades in.

However, rather than dispute Churchland on the irreducibility charge any further by relying on sketchy promissory notes of my own (about current or future developments in neurocomputation to bridge the gap between intentional psychology and neuroscience), I propose to shift gears and join him, instead, to see where the charge leads – straight to the heart of eliminativism's imperialistic agenda

Assessing the Significance of the Irreducibility Charge As I'll be arguing momentarily, despite Churchland's insinuations to the contrary, the concession that the generalizations of intentional psychology probably aren't reducible to the physical sciences isn't fatal to intentional

psychology's future prospects, for the simple reason that reducibility isn't a particularly important *desideratum* for the special sciences.

Churchland, however, seems to regard reducibility as an *essential* trait of a theory – one whose absence is a mortal failing. That would explain why he claims (in his 1988, p. 45, my emphasis) that the feature which *distinguishes* eliminative materialism from the other schools of thought in the philosophy of psychology is, "its denial that a smooth intertheoretic reduction is to be expected – even a species-specific reduction – of the framework of folk psychology to the framework of a matured neuroscience." However, it should be noted (and was, again by Patricia Kitcher [1984 p. 102]) that a belief in the fundamental irreducibility of intentional psychology to neuroscience is hardly unique to eliminativism. ***Dualists*** argue for the same conclusion (on the basis of *a priori* arguments about the distinction between the mental and the physical: see Descartes' *Meditations*, Brentano [1960] and Kripke [1977, 1980]), as do ***functionalists*** (on the basis of the multiple instantiability argument about how psychological or computational processes can be realized in a number of different physical substrata: see Putnam [1960, 1967], Fodor [1981], or my note @note["multiple]) but neither of these camps thinks that there's something wrong with the intentional approach on that account, or that we should therefore try to phase it out. Clearly, then, even friends of folk psychology concede that it probably isn't reducible to neuroscience or to some other more basic science. Hence our second question – so what if it ***is*** true that psychology won't reduce?

Before I answer that question directly, however, I should point out that what *truly* distinguishes E-M – since dualists and functionalists share its belief in the irreducibility of intentional psychology to neuroscience – is its agenda that physiology and ultimately physics should reign supreme, and its dogma that those theories and disciplines which *don't* reduce to physicalistic vocabulary ought to be ***eliminated***. According to Churchland's (1981, p. 72) unificationist doctrine, theories have to "win survival through intertheoretic reduction;" if categories like "belief" can't find a home in "completed" neuroscience, then they should simply be discarded and "displaced" in scientific contexts, as if it is a given that they have no independent merits. Of course, for these very reasons, there are some questions about whether eliminative materialism is even a *coherent* position, since it seems to deny itself the very cognitive resources it needs to make its case (such as theories, or the beliefs that there are or are not beliefs, etc.), but I will resist the temptation to digress about this issue at length and consign it to the notes, @note[Baker] in order to concentrate on the matter of psychology's reducibility. In particular, I'll be arguing that Churchland's view on the relative importance of reduction is decidedly impractical, and reflects an insufficient appreciation of the character of the special sciences.

According to Churchland (1981, p. 73), "we must evaluate FP with regard to its coherence and continuity with fertile and well-established theories in adjacent and overlapping domains – with evolutionary theory, biology, and neuroscience, for example," because "active coherence with the rest of what we presume to know is perhaps the ***final*** measure of any hypothesis" (my emphasis). Thus, despite the seemingly radical nature of Churchland's philosophy, there is at bottom a decidedly conservative cast to his brand of eliminativism, since he yearns for order, amenability to quantification, and tidy theoretical reduction (see, e.g., Churchland 1981), and opts away from a messy pluralism which emphasizes ***results***, instead.

But why should *coherence* or *consilience* with other theories be the final measure of a theory, as opposed to its ***utility***, for example? The reason Churchland (1981, p. 73) gives is tied to the notion of *truth*: "we must consider what sorts of theories are *likely* to be true of the etiology of our behavior, given what else we have learned about ourselves in recent history;" the basic idea seems to be that any theory purporting to describe reality had best fit in with whatever the sciences we think *are* true have to say. However, while that line of reasoning may seem reasonable enough, I shall be arguing that it fails to make the eliminativist's case against intentional psychology, for several reasons.

The first, which I can't emphasize enough, is that we should recognize the decidedly un-pragmatic character of the emphasis upon truth and "active coherence with the rest of what we presume to know" above all else. *Pace* Churchland, it's ***not*** the "final measure" of a theory – particularly an applied theory like psychology – whether it "actively coheres" with other theories or not, nor is it even a particularly *important* measure. Instead, the paramount issue is its value in helping us to deal with the practical problems in its domain. Thus, even if the explanations of folk psychology *are* false from the point of view of the lower sciences because they can give no adequate account of its theoretical posits, it may be entirely reasonable for us to continue to believe in and use them – just as we are justified in believing in and talking about the commonsense objects in the so-called "manifest" image, rather than insisting on viewing things as a strict physicist might do. E.g., consider Eddington's famous example of the two tables: the commonsense mid-size object, which carpenters have a working conception of in terms of categories such as "solid" or "dark brown," and the "scientific" table as it is understood by the physicists, which is constituted by a cloud of tiny colorless particles with relatively vast spaces between them. @note[Eddington] Even if the reductively inclined scientific realist such as Churchland (1981) were to insist on denying the existence of colors or dense solids or even tables (because all that exists are mass, spin, and charge), both carpenters and ourselves are a lot better off proceeding as if they do exist, because is it eminently useful to do so, and the same may go for beliefs and desires, as well. Indeed, as Churchland (1985) himself explains, the vast majority of entities we deal in – including things like tigers, elms, and apples – will turn out *not* to be genuine natural kinds figuring into the most basic laws of science, as mass, length, duration, charge, and energy are, but many are *practical* kinds which play important roles in useful practical laws. Fortunately, medical science shares this latter line of thinking, insofar as it justifiably has a far more eclectic, pluralistic, and pragmatic orientation than the unity of science approach advocated by Churchland at times; as I'll be arguing in more detail in Chapter Seven, because psychiatric medicine and medicine in general are willing to incorporate methods and theories from disparate approaches so long as they help achieve beneficial results, the eliminativists' predictions and recommendations are probably ill-founded, *whether or not* intentional categories comport with or are reducible to physical ones.

But since I don't want to keep selling psychology short on the idea that it is true, let's move on to a second weakness of Churchland's position on the importance of reduction: it draws too close a connection between truth and reducibility, because a higher level theory can be compatible with more basic theories, without actually being reducible to them. An appreciation of this point will take us straight to the heart of why we developed specialized sciences such as psychology in the first place: not so much because of the nature of our epistemic relation to the world (such as the fact that atomic particles are too small for us to see), as Fodor (1981, p. 144) points out, "but

because of the way the world is put together: not all the kinds (not all the classes of things and events about which there are important, counterfactual supporting generalizations to make) are, or correspond to, physical kinds." In other words, as Fodor (1981, p. 245) notes, the predicates of the special sciences such as Gresham's Law about monetary exchanges in economics "*cross-classify* the physical natural kinds," and we keep their taxonomy around to fulfill the scientific purpose of stating "such true, counterfactual supporting generalizations as there are to state," as well as to help deliver vitally needed services, as I've been arguing throughout this work. But even though the psychological kinds may not match up with the neurobiological ones, that certainly doesn't show that psychology is *inconsistent* with materialism or with the natural sciences, so long as token-token identities remains open to it (i.e., so long as each instance of a mental state is identical to some physical state or another), as Horgan and Woodward explain, @note[Horgan] and as we saw, the latter point is granted at least in principle with regard to representations by none other than Patricia Churchland (1986b, p. 250) in her reply to the ***Inquiry***.

Thus, special sciences such as intentional psychology or the even more specialized psychoanalysis shouldn't be eliminated if they don't reduce to more basic biomedical or scientific research, since it is possible for the explanations and generalizations of the higher and lower level sciences to <u>both</u> be true, even in the absence of bridge-laws between them. More importantly, the insights they provide may be complementary. E.g., as Kitcher (1984, p. 103) and Marras (1985, p. 298) both note, there is plenty of room for the functional level theories of computational intentional psychology to co-exist with the lower level sciences, since "Psychological explanations," as the former remarks, "will ultimately appeal to things like and-gates and neurophysiology will tell us how and-gates work. So although intentional psychology is irreducible to a more basic science, it would be fully integrated to a more basic science." Similarly, as Freud comments concerning the contrast between his interpretive approach to psychological problems and that of somatic psychiatry, "What is opposed to psycho-analysis is not psychiatry but psychiatrists. Psycho-analysis is related to psychiatry approximately as histiology is to anatomy: the one studies the external forms of the organs, the other studies their construction out of tissues and cells." @note{[SE] 16} And finally, even if the story the physical sciences are currently able to tell about *homo sapiens*' "constitution, development, and behavioral capacities" is a *coherent* one, as Churchland (1981, p. 75) claims, it isn't a very comprehensive one, it doesn't have much evidence to speak of, and it doesn't begin to do justice to our more complex behavior, as the philosopher of science Philip Kitcher argues in detail in his (1985) critique of sociobiology, so rather than being able to *replace* the intentional account, it needs to be ***supplemented*** by it. A dramatic illustration of this is provided by no less a figure than Socrates himself, when he is called upon to justify his decision to face his execution in Athens rather than fleeing, and he notes that lower level physiological explanations fail to provide much of an explanation for a subject's behavior, since they leave out his considered reasons and motivations. @note[Anaxagoras]

Contrary to Churchland's reductive inclinations then, the complaint that intentional psychology's categories and generalizations won't reduce to the more basic natural sciences lacks force – not so much because it's false (though it may well be, by the Churchlands' own admission) as for the fact that even theories that are regarded as both useful <u>and</u> true might not reduce to the lower sciences, a fact which doesn't detract from their scientific, practical, ***or*** truth value. Ironically, if

Churchland wants to maintain *neuro*eliminativism, he would do well to relinquish his insistence upon the importance of reducibility and grant this general line of argument about how the higher levels of more specialized sciences can co-exist with lower ones, because as both the Kitchers have argued, the same considerations apply to neurobiology itself – important aspects of it such as transmission genetics may not be reducible to the more basic sciences, either. @note[transmission] Thus, even some sciences that are thought to be in good standing from the naturalists' point of view might not be reducible to more basic theories, which suggests that reducibility isn't truly a mortal failing, after all. So even if intentional categories do "stand magnificently alone" and fail to "find themselves neatly reflected in the framework of neuroscience," we shouldn't abandon them on that account, anymore than we should discard the categories of agricultural science, should they fail to be "neatly reflected" in the categories of physics, just so long as they continue to be explanatory or useful.

Having now dispensed with Churchland's allegations that intentional psychology will be eliminated because it "suffers explanatory failures on an epic scale" (PMC 1981, p. 76) and because it won't reduce to the more basic sciences, then, let's press on to examine his third and main argument, which concerns its allegedly long history of stagnation.

Judging Folk Psychology's Future From its Past

In the first leg of his main historical argument in favor of neuro-eliminativism, Churchland contends that a close look at the history of "folk" sciences in general and at psychology in particular will reveal that the person-centered intentional paradigm is a "dead-end" approach (1979, p. 115) which seems ripe for "outright elimination," because it's been "stagnant" for millennia (1981, p. 75), and "it'd be a miracle" if we'd managed to get psychology right "the very first time," since we messed up so badly on less complex matters (1988, p. 46). @note[dearth] And in the second, Churchland maintains we'll be dropping intentional psychology for a theory with a "prettier face" (1979, p. 115) when we eventually forsake its categories and practices for those of some successor theory – namely, neuroscience or neuropsychology, which he characterizes as a far more recent development that's much more likely to be true, especially given its affinities with the other sciences (1981, p. 67; 1988, pp. 45-46, 144-45). In rebuttal, I shall be arguing that each of these supports for the neuroeliminativist platform are faulty or unsound, not only because the face of contemporary neuropsychology is more hideous than it is pretty, as I'll be arguing extensively in Chapter Seven, but also because there are a number of problems with Churchland's characterization of the historical situation, which I shall now elucidate in detail. In particular, I'll be drawing on historical texts to argue that there has indeed been progress in the intentional paradigm over the years, given its increasing recognition of the influence of unconscious processes, and also that contemporary neuropsychology isn't nearly so progressive as its advocates let on, given its associations with the classic "four-humours" theory of ancient "folk" medicine and chemistry. But before I review the actual evidence behind these claims, I want to take a moment to assess the ***force*** of Churchland's initial historical charge that intentional psychology has stayed pretty much the same over the ages, even supposing he *did* (or ***could***) furnish the evidence to back it up.

Suppose, that is, that the implicit claim that the Greeks were every bit as good intentional psychologists as Freud, any day, is *true*; @note{Whiggish} what conclusion about intentional psychology's truth or practical value should we draw? As I'll be arguing, "None," but as we've seen, Churchland opts for the far more pessimistic conclusion that folk psychology is probably a *false* and radically misconceived account of our behavior. Indeed, in this (1988, p. 46) passage, Churchland even concludes that "it would be a miracle" if we *had* managed to get folk psychology right back then, bolstering his opinion with an induction over the fate of other failed "folk" theories:

> Our early folk theories of motion were profoundly confused, and were eventually displaced entirely by more sophisticated theories. Our early folk theories of the structure and activity of the heavens were wildly off the mark, and survive only as historical lessons in how wrong we can be. Our folk theories of the nature of fire, and the nature of life were similarly cockeyed. And one could go on, since the vast majority of our past folk conceptions have been similarly exploded. All except folk psychology, which survives to this day and has only recently began to feel pressure. But the phenomenon of conscious intelligence is surely a more complex and difficult phenomenon than any of those just listed. So far as accurate understanding is concerned, it would be a ***miracle*** if we had got ***that*** one right the very first time, when we fell down so badly on all the others.

However, I shall be arguing that these aspersions Churchland casts upon psychology's validity for its alleged lack of progress are unwarranted, on several grounds.

To start with, it's a mistake to characterize the intentional paradigm as being "the very first time" we'd tried to account for human behavior. Before the notional world intentional model first came into prominence at the period Churchland first mentions in connection with this charge (the fifth century B.C.), behavior – particularly unusual behavior – was explained by the "Sacred" model (as Roccatagliati [1986] terms it) which preceded it. Unlike the former, which emphasizes the internal causes of behavior (as we've seen in Part I and will see again here in Part III), the Sacred tradition regards "madness" and irrational behavior as the results of "psychic intervention" (as Dodds [1951] describes it) on the part of external and even supernatural forces such as gods or demons, while troubling dreams were thought to be their messages, which needed to be interpreted by temple priests in therapeutic rituals and prophecies. @note{@ux[external]} And even apart from its belief in the supernatural agencies which spur us on, this earlier conception of what we now call the mind differed, in that it didn't really regard us as *having* integrated minds or personalities. @note[@p'psyche'] In contrast to this more fractured account, the psychology of the Hellenistic Greeks and their successors is at great pains to explain how individual behavior arises from a system of internal impulses and functions whose conflicts can be unified by a conscious self, and thus it represents a marked departure from its predecessor. E.g., as Roccatagliata (1986, pp. 22-23) notes, the early intentional psychologists, such as the poet Hesiod in the seventh Century B.C., @note[Hesiod] and later the Sophists, who made man "the measure of all things," rejected the mythic accounts of abnormal behavior and mental diseases and located the problem inside man, until by the fifth century B.C., Socrates had

> ... made guilt immanent....The roots of evil were no longer thought to be mythological but to lie within the soul, and they were identified with lack of knowledge. The source of mental diseases was not in the gods or in the body, but rather in the soul: it was therefore an ethical phenomenon. Knowledge of oneself was necessary for psychological balance; the dream was not divine but a privileged means of knowing man's inner world, of learning the genesis of instincts and impulses.

We'll be returning to the Sophist's views in due course, but first, even if they *did* hit upon the intentional framework on their very first try, why should we think it would be *miraculous* if ancient folk had managed to hit upon the truth in the process in this particular case? Even aside from the incredible *hubris* of the suggestion that the ancients were probably wrong about all empirical matters, unlike modern scientists – an attitude which has already resulted in the *nemesis* of a myriad medically-induced illnesses (as Illich argues in his [1976], and I in my Chapter Seven) – I submit that the "miraculous" charge and the "guilt by association" character of the pessimistic induction are unfounded, because there are some unique characteristics which set human psychology apart from those areas of folk inquiry whose theories have come and gone.

As we'll be seeing in some detail, the first reason it'd be no miracle if we'd gotten it right way back then is the fact that the Greeks of the Golden Age, some of the greatest minds who ever lived, applied their formidable powers of observation, classification, and reasoning to the problem of understanding how minds work, and it's no wonder if we haven't been able to significantly improve upon their insights into our fundamental psychological characteristics and functions since (although we have). As Wilkes (1984, p. 356) puts it,

> the reason we are 'neglibly better' [at explaining behavior than was Sophocles] is not that the 'theory' of common sense is one that has been stagnating for millennia, which is Churchland's diagnosis. It is rather that the Greeks were already brilliant at psychological explanation.

But brilliance isn't enough, of course, to win our confidence that a theory has truly understood an empirical matter: keen observation is also required. But here, too, the intentional paradigm shines, because we didn't need to await the development of complicated technology to gain insight into people's reasons, because we became outfitted with a far less costly and more valuable resource to study how peoples' minds work is required: an insightful and observant mind, which can study how people live, listen to what they say, and also pay close attention to what goes on inside itself. I'll be discussing the importance of the epistemic access that introspection provides momentarily, but first, I should explain how it fits in with the type of socio-neuro-bio-logical account Churchland seems to favor.

According to Churchland's own (1979) analysis, organisms on the go such as ourselves are ***epistemic engines***, who/which extract information from the environment to further our own survival. Since it's only natural (-istic) to assume that our brains have evolved so that they devote their maximum attention and resources to the things which concern them the most, then it follows that we may well have got psychology right quite early on in our development, because it wasn't something we could afford to study just at our leisure – it was vital to our continued survival that we have at least a rough understanding of the reasons behind not only one another's behavior, but also our predators' and prey's, as well, not only when we're dependent infants, @note[Vonnegut], but also when we're adults attempting to cooperate and band together for mutual protection, as the philosopher Graham and the historian Kantor each argue in the note. @note[Kantor] Thus, as the biologists put it, we may have been *selected for* our ability to understand and predict intentional behavior.

But not only did we have more ***need*** to get psychology right than we did some of the more arcane questions (such as the Churchlands' notorious, "How do the crystal spheres turn?"), and not only is it the case that so many more investigators have paid more attention to what makes

people tick than we have to any other question, but we've also had far more ***evidence*** at our disposal. Not only is the phenomenon under study (the behavior of humans and higher animals) ubiquitous, as Kantor (1963, pp. 42-43) pointed out, but we also have far more direct observational access to it. Unlike the other sciences, the intentional paradigm didn't need to await advanced technological breakthroughs such as microscopes, CAT scans, or particle accelerators for its investigators to get a grip on the phenomena it studies: we came – or became (if Jayne's [1977] adaptationalist thesis about the difference between pre- and post-Homeric man in this respect is correct) – equipped ourselves with the necessary wherewithal to be able to observe and know about psychological processes ***firsthand***. Of course, we don't always employ this capacity for conscious introspection well, but I'd wager that its existence no doubt had a lot to do with the development of intentional psychology in the first place, and that it gives us more of a handle on mentation than we have on any other phenomena (such as "cold fusion," where we don't know where the few measurements we get are coming from).

When you put these factors together – the fact that others' behavior is very salient and very important to us, plus the fact that we have been equipped with the necessary means for recognizing intentional phenomena such as desires and intentions in ourselves – it should be readily apparent that it would be anything *but* miraculous if folks *have* managed to at least roughly understand human conduct early on, because we've devoted so much of our attention to it over the years, and we have so much more attention *to* devote to it than we have to the study of the heavens or the microscopic world. With so much more riding on it, and so much more evidence and means of obtaining it at our disposal, we've had the inside track in understanding ourselves, and thus psychology is unlike the other "folk" areas of investigation which *have* fallen flat, so the Greeks might very well have got things essentially right "the very first time" (although as we've seen, that would be a distortion of the historical situation).

Finally, even if Churchland's conclusion that folk psychology is false *were* true, it should be noted that he is much to quick to assume that it's therefore likely to be *eliminated*, in favor of neuroscience or anything else. He overlooks the fact, which is argued by Larry Laudan in his *Progress and its Problems* (1977), for example, that a theory's truth or falsity and its utility aren't necessarily connected. Thus, before we conclude that interpretive psychology will be eliminated like the other folk theories have been once they've been found to be false, we should bear in mind that it's not even the case that the folk theories which *have* been shown to be demonstrably false or stagnant *have* been extinguished. @note[McCloskey] If a theory continues to be useful, at least for some purposes, then people are going to continue to use it anyway, even if it is false. If the phenomena being addressed such as midsize objects and people ***do*** permit rough and ready measurements of their states (though that's *all* they'll permit, in some cases) which enable us to deal with them reasonably effectively, then we shall continue to make do with such heuristics (even if that's all they are). In short, *we shouldn't and probably won't eliminate useful applied sciences*, despite the theoretical and aesthetic predilections of more formalistically inclined academics.

In sum, then, it seems that there's *not* much force to Churchland's initial charge at all, even if he *did* have the historical evidence to back it up. However, since the charge that a paradigm is "stagnant" tends to harm its chances for adequate funding by agencies that are more concerned

with "progress" than with good work unless it is answered directly, I shall now review the evidence, and argue that it contradicts his claims altogether.

The Historical Argument

The historical argument is an inductive argument over the fate of other "folk" theories which have been displaced. In short, Churchland (1988: 46) claims that it would be a "miracle" if we'd got *this* one right, given both the fate of other "folk" theories, and the extreme complexity of this particular phenomenon, our psychology. Moreover, Churchland (1981: 74-75) also contends that "the history of FP...is one of retreat, infertility, and decadence" and that it should be considered a "stagnant" discipline, since,

> ... both the content and the success of FP have not advanced sensibly in two or three thousand years. The FP of the Greeks is essentially the FP in use today, and we are negligibly better at explaining human behavior in its terms than was Sophocles. This is a very long period of stagnation and infertility for any theory to display, especially when faced with such an enormous backlog of anomalies and mysteries in its own explanatory domain.... To use Imre Lakatos' term, FP is a stagnant or degenerating research program, and has been for millennia.

To support a claim such as this, one would expect Churchland to provide a detailed examination of ancient texts to show that intentional psychology *has* remained "essentially the same" for 2 1/2 millennia, but he actually provides no evidence at all. Having reviewed some of the history behind both paradigms in question, my rebuttal to the historical argument proceeds as follows: first, I'll argue that even if he's right about intentional psychology's lack of progress, that doesn't mean that it's probably false; and second, he's not right, because there have indeed been significant advances in the intentional paradigm within the past couple of centuries alone.

Now, suppose for the moment that it's true that intentional psychology hasn't changed all that much since Sophocles' time. Does that mean that it's either infertile, untrue, or ripe for elimination? Not at all, for several reasons. First, it should be noted that there is a kind of hypocrisy or double-standard implicit in Churchland's position, since he is faulting psychology for apparently having reached the end of its development, which somehow compromises its scientific status and counts as "stagnation" and "infertility," even while simultaneously holding out the promise of a "completed" and presumably ***true*** neuroscience – e.g., twice in the short passage in Churchland (1981: 67) quoted earlier. Second, even if psychology reached its zenith of development long ago, it might continue to yield important and even indispensable practical or therapeutic results, nevertheless – and as I'll point out in the next section, indeed it does, as the NIMH and other studies indicate. And third, even if the psychology which first began to flourish with the Hellenistic Greeks was "the very first time" we'd attempted to come to terms with peoples' reasons for behaving – and it wasn't, because prior to that time the "Sacred" tradition prevailed, which accounted for events in terms of the whims of the Gods or possession by demons – this doesn't show that it's probably <u>false</u>, because the Greeks were so insightful that they just might've got things right, contrary to Churchland's insinuation that it would be miraculous if they had. This isn't only because the ancient Greeks had some of the greatest minds that ever lived, but there are also a number of factors which differentiate psychology – humans studying their own behavior – from the other areas of inquiry which they may not have been so successful at. For one thing, unlike the more esoteric topics which the Churchlands like to fasten upon, such as "What makes the crystal spheres turn?", this is an area that we probably

had the greatest need to come to grips with, given that we are social animals who need to understand and get along with one another in order to survive, and we probably devoted more attention to it. For another, it's subject domain is one we probably have the greatest access to, not only given the ubiquitousness of the phenomena (ourselves), but also due to our introspective capacities; the point is, intentional psychology didn't have to await the development of fancy CAT scans or microscopes or particle accelerators to gain some understanding of human motivations – it requires a far less costly and more valuable resource – namely, insightful and observant minds, and as their various dramas and writings indicate, the Greeks certainly had that. So, all in all, we have probably dedicated more resources to it than to other folk concerns, so we may very well have got this one essentially right.

Finally, in order to both reinforce my point about the intelligence of the ancient Greeks and place the neuroeliminativists' implicit claims about their own paradigm's progressive nature into proper perspective, I should also point out that some of these self-same Greeks were responsible for originating the neurobiological paradigm. Thus, if the criterion for being "stagnant" is being continuous with the Greeks' accounts, I should caution that the medical model is guilty, too, because the contemporary accounts of mental illnesses in terms of biochemical imbalances have striking parallels to the theory of "humours" forwarded by Hippocrates and other early proponents of the physicalist or medical model.

The Early Emergence of the Neurobiological Paradigm As we've seen, Churchland (1988, p. 46; 1981, p. 74) seems to put a lot of stock in the fact that "folk" psychology has been around so long – he sees it as a sign of stagnation. And as we've also seen, Churchland draws attention to the fact that a good deal of intentional psychology was indeed developed in antiquity. But what he doesn't mention is a fact of considerable relevance to this contest between the two paradigms: namely, the medical model has been around just as long. Thus, I shall now be turning the tables on neuropsychology once again (as when I argued that neuroses are better recognized as psychological problems than as medical ones), by discussing the historical evidence about the origins of the medical model in connection with the question, "Have folk ***medicine*** and folk ***neuropsychology*** really progressed so much?" This evidence, I hope to convince you, shows either that Churchland's "stagnation" charge can cut both ways to indict neurobiology, as well, or it falsifies or undermines his suggestion that any paradigm that has roots over 2,000 years old should be regarded as "stagnant."

The fact is (although it tends to be obscured in eliminativist discussions equating "belief-desire" talk with superstitious beliefs in witches and demons), folk psychology isn't the only approach to abnormal human behavior and mental disorders that emerged around the fifth century, B.C. (the period Churchland mentions). We've already seen in some detail how the Hellenistic Age gradually largely abandoned the Sacred account which preceded it, in favor of a psychological approach which internalized motivations such as guilt. But what you may not also realize is that a second rival paradigm, which also severed the hypothesized links to the supernatural deities and demons which allegedly controlled us, emerged at the same time: biohumoural medicine, the ancestor of the current neurobiological hypotheses.

Folk medicine has, it's true, progressed beyond the crudity of positing wandering reproductive organs or "animal spirits," but they're still explaining mental "illnesses" as imbalances in our

"precious bodily fluids" (as Kubrick's Gen. Jack D. Ripper puts it in *Dr. Strangelove*). Whether it's put in terms of "nerves" (as it was in the nineteenth century, as we saw in Section 8.2.2), or in terms of neurotransmitters (as we'll see in detail in the next Chapter), or in terms of the "biohumours" (according to the ancient theory we're about to hear about), physicians have been saying that mental disorders are due to physiological imbalances for a very long time, long enough to count as a "stagnant" claim, according to Churchland's "over two thousand years" criterion. In this section, we'll review the theory of the biohumours in general, and its account of melancholy or depression in particular, to put the neuroeliminativists' claims about their own paradigm's progress in proper perspective.

Hippocrates of Cos, a contemporary of Socrates who was born around 460 B.C., whose theories of hysteria we heard something of in Section 8.2.2, is the most famous of the early developers of the medical model. As one of the first ***physicians***, he favored physicalistic explanations, which resemble the psychological paradigm insofar as they reject any reference to the alleged gods' wishes and locate the problem inside the afflicted individual's body, but rather than substituting the account of daemonic possession with talk of intentional states, he spoke of the imbalances in the bodily "humours," instead.

To start with, Hothersall (1984, p. 5) sketches the outlines of the overall biohumoral account for us here:

> In his treatise, *The Nature of Man*, Hippocrates presented a theory of humors. Empedocles had described the universe as composed of four unchangeable, but intermingling, elements – air, earth, fire, and water. According to Hippocrates, these elements form four basic humors in the body: black and yellow bile, blood, and phlegm. An imbalance or excess of any one of these humors would produce disease or illness. Phlegm collects in the nose and throat when one has a cold; when the skin is broken blood is seen; bile is excreted from the body following a serious wound. Hippocrates' theory of humors influenced the diagnosis and treatment of disease for many centuries. Bloodletting to vent excessive blood was practiced well into the nineteenth century.

Similarly, as Roccatagliati (1986, p. 162) records,

> Hippocrates made use of the physiological paradigm as it had been elaborated by Thales, Anaxagoras, Anaximander, and Anaximenes. He meditated critically on that monistic approach, and he proposed an original interpretive model for psychopathology, which was new in respect to all the cultural traditions of the past. He did this by introducing the biohumoural interpretation and the neurocentric hypothesis which stated that the brain was the center of mental life and of the affective and emotional sphere, and that a primary or secondary alteration caused by a humoural disequilibrium led to the mental disease.

Finally, the outlines of the general biohumoral theory are presented for us in a little more detail here by Brett (1965, pp. 57-58), who writes that for Hippocrates,

> ...it is clear that the fundamental requirements of life are spirits and humours. Considering first the physical structure, we find that the basis is the four elements – air, fire, water, earth. To each of these substances corresponds a quality called dry, hot, moist, or cold; and again in correspondence with these a Humour, namely, blood (warm), phlegm (cold), yellow bile (dry), black bile (moist). Health is defined as the right mixture of these; disease is consequently a disturbance of the relations, usually expressed as a change of ratios. The body not only requires to maintain definite relations between its own elements, but also to stand in certain relations to the universe around it. Its nurture depends on three things – food, drink, and air. To the ancient mind the 'air' seems to have been a generic term for all causes of disease other than those of food and drink. The vascular system was divided between veins and arteries, and the opinion most widely accepted was that the arteries contained air while the

> veins contained blood. This extreme doctrine was afterwards modified, and the air and the blood were located together in the same vessels. To one who thinks of the body as irrigated throughout by air, who attributes the cause of pulsation to the shock of air meeting blood, who moreover feels dimly that man is in direct connection with the whole universe through the continuity of this air, the importance of this factor must have assumed the greatest importance. Within the body the brain occupies the most important place. From it proceed all the veins of the body: they spring up from this root and grow downwards, branching out to the various parts of the body. Here is the seat of intelligence: into the brain lead the various passages of sense – eyes, nose, ears. It is from the brain that the eyes derive the humour that feeds the pupils; and all diseases begin from the brain because from it flow the humours that are found throughout the body.

To be in bad humour in general, then, is to have an imbalance in the proper mixture of the four main bodily fluids. While the theory of biohumours in general may not seem to have a good deal of resemblance to current neurochemical hypotheses, it, too, is, as was noted, a physiological account, but more importantly, its account of melancholy in particular, to which we shall now turn, has striking parallels to the contemporary account which will be occupying us in the next chapter.

As Roccatagliati (1986, p. 170) remarks,

> For about a century [prior to Hippocrates' time] the physiological literature had reported that a concrete part of the body, the black bile, was the specific cause of melancholy. Melancholy was a disease concretely homologous to the pathogenic humour: black, obscure, dark, dry, cold. All the physiological literature before Hippocrates supported this hypothesis, which had been accepted by Empedocles, Philolaus, Euriphon of Cnidus, Timotheus of Metapontus, Alcmaeon, and Phyllistion of Locri. Melancholy, they all agreed, originated from an excess of black bile.

Let's concentrate on the Aristotelian version of the black bile hypothesis, however, because it provides a fuller account, which Simon (1978) will summarize for us here.

In section 30 of the *Problemata*, Aristotle (or more likely, one of his disciples writing under his name, probably Theophrastus, as Simon 1978, p. 228 notes) advances a biohumoural understanding of melancholy, in response to the question, "Why are men of genius, including Plato and Socrates, melancholics?" As Simon (1978, pp. 230-31) explains,

> We are now in the realm of a fairly well-formulated theory of humors and their relation to "constitution." We are speaking here of the melancholic in contrast to the phlegmatic, the sanguine, and the choleric. In a person with this temperament, with the balance of the humors dominated by black bile, frank melancholic diseases may erupt. ...The author compares the effects of black bile and the effects of wine. By providing an example of a known substance that produces a variety of effects on the mind and temperament, he lends plausibility to the notion that an internally occurring substance can produce similar mental effects. Wine can make some men angry, some kindly and merciful, and some impulsive. Further, one can observe that wine produces these changes gradually. When a man who is sober and "cold" (without much natural heat) begins drinking wine, he may become a "speechmaker" and be more bold, then impulsive, then maniacal and raving, then foolish ("morons"), like some of those who have suffered from epilepsy since childhood. The variety of traits induced or elicited by wine is naturally distributed among men; that is, variations in the amount and quality of black bile are responsible for the incidence of these naturally occurring traits. Wine produces them for only a short time, while black bile produces long-term and permanent effects. ...The author then seeks to build a theory that will invoke only one simple substance as the cause of a variety of phenomena in melancholics. Thus he argues that the qualities of black bile may vary, particularly its temperature, and that the variations in qualities can explain why a variety of effects may be produced by only one substance. Cold black bile leads to apoplexy, numbness, fearfulness, and being disheartened (*athumia*). Hot black bile produces "cheerfulness, bursting into song, and

> ecstasies, and the eruption of sores." Now, the ordinary amounts of black bile arising from food ingested do not affect the characters of most people, though | in sufficient quantity bile may lead to some physical melancholic disease (presumably transitory). But in those with the basic melancholic constitution one finds characteristic illness, the nature of which depends on the proportions of hot and cold black bile. Coldness and a moderate amount of bile make men sluggish and stupid, while excessive quantity and heat lead to euphoric, erotic, impulsive, and garrulous behavior. If hot black bile is too near the seat of the intellect...the individual is affected by a "manic" and "enthusiastic" state. Such people may become Sibyls, Bacchants, or "god-struck." But when the amount of black bile is more moderate (and presumably the right temperature), melancholics become more intelligent than most people and tend to demonstrate talent in education, the arts, or politics. Cold bile makes one cowardly, while warm bile allows one to deal with fear and remain steadfast. Daily fluctuations in mood, from sad to cheerful, are also explicable in terms of variations in the mixture of hot and cold bile....If cooling is too sudden or excessive, extreme despondency leading to suicide can result, especially in the young.…

As I mentioned, this bile-chemical explanation of melancholy has certain obvious parallels with the contemporary neurochemical hypotheses we'll be examining in detail in Chapter Eight, which theorizes that depression is caused by a relative inactivity of certain neurotransmitters (norepinephrine and/or serotonin), while mania is believed to be the result of excessive concentrations of them – similar to the "hot and cold bile" spectrum – which is why Simon, an M.D., comments, It is tempting to say that he outlined for us the equivalent of one of the modern biochemical theories of the etiology of affective disorders. His arguments about black bile constitute a respectable precursor of the catecholamine hypothesis of depressive and manic disorders of the brain...that excesses of norepinephrine and related substances, acting in certain parts of the brain, lead to mania, while deficiencies and depletions of these substances lead to depression. (Simon 1978, p. 234)

There is, however, one notable difference idiosyncratic to Aristotle: he doesn't think that its primarily the *brain* that these chemicals are working on or in, as Simon (1978, p. 230) notes, since he thought that the brain was a cooling organ while the heart did the thinking. That aside (a relatively minor point, from the functionalist's point of view, after all, so long as some organ or other gets the job done), the resemblance between the ancient and modern accounts of so-called "endogenous" or naturally occurring depression is made even plainer in this passage from Roccatagliati (1986, pp. 108-109), commenting on the same work: in Aristotle's opinion,

> ...melancholy resulted from an endogenous dismetabolism of the black bile....The cause of melancholy and mania was "an excessive cooling or heating of the black bile." These variations in temperature, called *combustiones*, occurred "without any reason at all"; they were unmotivated from a psychological point of view. The cooling of the black bile led to a "slowing down, depression and anxiety," whereas its heating cause "euphory, excitement, and exhilaration." The two opposite poles of the cyclothymic psychosis are mentioned here.

But not only is the ancient physiological *theory* of depression similar to the current one, but its ***treatments*** are, too. Although it only recently came into its own as a separate department in the universities, psychopharmacology has also been around since before antiquity. As Ellenberger (1970, p. 37) remarks, "It is well known that modern pharmacopoeia derives a large number of its most active drugs from primitive medicine." In particular, substances such as opium and hellebore roots have been applied to soothe woes and to purge physiological imbalances, at least since the time of Homer. @note[hellebore roots] Similarly, the tranquilizer reserpine, which ushered in the modern pharmacological era, was manufactured from extracts from the root rauwolfia, which had been used in India for centuries as a sedative. @note{rauwolfia} And as

for the treatments the biohumoural model in particular recommends, as Roccatagliati (1986, p. 171) remarks, quoting Hippocrates

> Melancholy was thus interpreted according to a precise biochemical model, as the expression of a biohumoural disequilibrium: "sadness, anxiety, moral dejection...tendency to suicide...they should therefore be treated with derivatives...extracts of the roots of mandrake or hellebore...also convulsions have a beneficial effect."

As we'll see in Chapter Seven, even today, convulsions are induced to ward off serious depression, while some of the autonomic side-effects of anti-depressants approximate the effects of the hellebore root, an emetic.

As we'll see in a good deal more detail in Chapter Seven, the biomedical approach to depression is still deadlocked with the psychological approach, which sees it as a problem with the subject's attitudes about himself and his future, rather than as a problem with his physiology. For the moment, however, before we play out the same old debate, I want to emphasize once again just how old the debate is. As you can see from these remarks by Simon (1978), in a sense, the neuroeliminativist position itself is old as intentional psychology itself, since the Hippocratic medical tradition located people's problems "not in the inner conflicts that might beset them, the tremendous competitive pressures to which they might be subject, or the extremely high standards that they might set for themselves" (Simon 1978, p. 232), but rather in their constitution, and since

> ...it is abundantly clear that the Hippocratic doctor had no professional interest in the patient's personal emotional difficulties, whether the illness was conspicuously physical or mental. Such a concern was simply not part of the physician's conception of his professional activity...overall, ancient medicine did not develop a concept of the healing power of words and dialogue, just as it did not develop a concept of disturbances of the mind apart from disturbances of the body. On the contrary, one gets from the Hippocratic authors the sense that anything not couched in physiological and physical terms already touched on magic and charlatanism. (p. 227)

The Sophists, on the other hand, as we've seen, held that "the mentally ill had to 'purge their souls from sin,' not through the use of hellebore or rites in the Aesculapian temples, or medical cures as preached by Hippocrates's biological orientations, but, instead, through psychotherapy" (Roccatagliati 1986, p. 39). Moreover, as Roccatagliati (1986, p. 38) also notes,

> Sophism...accentuated the polemic against the naturalistic trend of the philosophers of Ionia, who wanted to explain psychopathology in terms of metabolic modifications of basic physical elements. The Sophists declared this biological model to be "as vain as a child's story." The central psychological problem was the harmony of the soul, which derived not from a biological balance, but rather from inner knowledge, from self-control of the forces of the inner evil. The basic task of the philosopher, and not of the physician, was to elaborate an adequate art of living in order to control psychopathological attacks. Folly and lack of knowledge were the same thing. The sick person could not be saved by magical or medical cures. His soul could only be purified by words which directed the reason toward virtue; psychic symptoms were the expressions of "vice, wickedness and ignorance." @note{@p'Sophist'}

As you can see from this discussion, then, the debate over the proper understanding and treatment of "mental illness" has been going on a very long time, so long, in fact, that if the psychological paradigm is "stagnant" on account of the fact that its roots are over two thousand years old, then so is the medical model, since it has been around for fully as long. But before we leave this introduction to the ancient counterparts to the contemporary dispute, it should also be

noted that there were also many who took a more eclectic approach to psychiatry in antiquity, just as many do today, by combining both psychological and somatic insights and treatments. E.g., as Roccatagliati (1986, p. 9) observes when discussing the Homeric figure Melampus, The priest-psychiatrist sought primarily to eliminate the disease that was in the soul by means of pharmacological substances such as hellebore; suggestive rites; interpretation of dreams; psychoagogic advice; and use of songs, music, and dancing. By these means the priest purged the soul of its evil parts which had acted as toxins of the mind and had alienated it.

With that by way of a general introduction and overview to the historical roots of both the two rival paradigms, let's proceed to Churchland's claim that it would be a "miracle" if the Greeks had managed to get psychology essentially right back then.

Would Intentional Psychology's Ultimate Success be a Miracle?

This claim invites a number of replies: first, as I've already indicated, Aristotle's psychological account wasn't the very first time people had tried to account for people's behavior, rational or otherwise; second, Churchland's criticism seems to be based on a double standard in the light of his remarks about a "completed neuroscience"; and third and more importantly, due to the vital importance of psychological phenomena as well as our increased access to them, it wouldn't be so miraculous if we had managed to understand them fairly early on in our development.

Let's start with the second matter. At first glance, there is a kind of hypocrisy or double-standard implicit in Churchland's position, since he is faulting psychology for apparently having reached its zenith ages ago (which somehow compromises its scientific status), even while simultaneously holding out the promise of a "completed" neuroscience right from the beginning. In this short passage from Churchland (1981, p. 67) defining his position, for example, he refers to neuroscience's much awaited completion *twice*:

> Eliminative Materialism is the thesis that our common sense conception of psychological phenomena constitutes a radically false theory, a theory so fundamentally defective that both the principles and the ontology of that theory will eventually be displaced, rather than smoothly reduced, by completed neuroscience. Our mutual understanding and even our introspection may then be reconstituted within the conceptual framework of completed neuroscience, a theory we may expect to be more powerful by far than the common-sense psychology it displaces, and more substantially integrated with the physical sciences generally.

This seems like a double standard, because we're told that it's the mark of the "stagnation" and "infertility" of a "folk" theory if *psychology* has reached the end of its development, while it's the "completion" of a good science if neuroscience ever does. However, Churchland can no doubt reply that he is not alleging that there is anything suspect about the idea of a theory getting it right *tout court* (at least not at this juncture, although he has since gone on to renounce "convergent realism," as it is called -- see his 1990____) – just that it'd be miraculous if intentional psychology had succeeded in doing so "the very first time" – so let's proceed to that first claim.

That characterization of the historical situation is, of course, a distortion, for several reasons. We've already heard two: Aristotle himself starts his *De Anima* by drawing on the work of earlier Greek naturalists and psychologists, as I noted in 7.2.1.1; and the internalized notional world account of irrational behavior differed from that of the externalist Sacred tradition which

preceded it, as we saw in 7.2.2. And there's a third reason, as well, which will be presented by our next witness, the psychological historian J.R. Kantor: the Greeks themselves were drawing on earlier societies' practices and reflections.

In his *The Scientific Evolution of Psychology*, Kantor (1963) responds to the claim that the Greeks were miracle workers years before Churchland even (perhaps unwittingly) repeated it, by providing an account of the origins of scientific paradigms that presages Philip Kitcher's recent work, as well. Of course, Churchland isn't really claiming that it *was* a miracle (rather, he's offering a *reductio* that it i*would've* been a miracle if the Greeks had gotten thing essentially right -- and so they probably didn't) but Kantor's response applies to the miraculous claim just the same as if it had been asserted in earnest. To begin with, Kantor (1963, pp. 37-38) cautions us not to fixate on the finished product instead of on the processes that led up to it:

> Science is frequently defined in terms of its final formalized products as a system of propositions and equations embodying the laws concerning events. Nevertheless, this is an improper procedure. It is grossly misleading to overstress the end product to the neglect of the many complex operations which eventuate in those laws. To bypass all that happens when laws are developed makes possible the confounding of events with law propositions and even with the language expressing these propositions....Scientific systems are all rooted in earlier presystematic periods which antedate organized research and the accumulation of theories.

Sciences in general, then, are preceded by protosciences, and as for protopsychology in particular, Kantor (1963, pp. 68-69) addresses it and the miraculous claim directly in a section called "Greek Science: Miracle or Evolution?":

> It is impossible to minimize the glorious achievements of the Greeks in the development of their unsurpassable arts and sciences. But by the same token it is folly to believe that the Greeks were miracle workers. Even the fact that we are partially their direct cultural descendants can blind us to the obvious origin and development of the particular objects and technics we most admire in their civilization. Accordingly, we are obliged to take into account all the cultural tributaries that have flowed into the great stream of Greek achievements in psychology and the other sciences.
>
> In recent years there has been a laudable effort on the part of scholars to correct the mistake of regarding Greek accomplishments as ungenerated, as novelties suddenly arising by spontaneous creation. Many evidences are now accumulating that an authentic evolution in all phases of Greek culture has occurred. The influence upon the Greeks of what happened in Babylonia, Egypt, and other neighboring and more distant civilizations is becoming known with increasing precision....The pre- and proto-sciences evolved in the Near Eastern civilizations have found their way into the sciences the Greeks synthesized and brought to a remarkable point of completion....When the historian of science becomes familiar with original materials concerning the scientific work of the Babylonians, Egyptians, and other precursors of the Greeks, he cannot avoid seeing Greek science in its proper perspective. It becomes clear to him that the Greeks owe a great debt to their forerunners just as the successors of the Greeks, in their turn, are obligated to the Greeks.

So Churchland shouldn't speak as though folk psychology suddenly sprang up in full dress like Athena herself, because that completely oversimplifies the long development that undoubtedly occurred prior to the Hellenistic age. But even if it had --

Let's explore these points briefly in turn.

First, let's consider the thesis that there have been no appreciable developments in the intentional theories in all this time. In making this claim, Churchland totally overlooks the flourishing of the

field of clinical psychology and the fact that there have been significant advances in the theory, practice, and scope of application of intentional psychology in the last hundred years or so.

First, although its fundamental ontology (beliefs, desires, hopes, fears) may not have changed much over the years, there have surely been progressive refinements – not just in the number of attitudes identified (to include "chagrin" or "pusillanimous," for example), but also in the basic models of the way the mind functions, with most people now acknowledging the presence and extensive influence of ***unconscious*** processes and motivations. As a result, the applications of the intentional approach have been extended as well – to encompass not just overt purposive behavior, but also hysteria and various psychosomatic conditions which were once thought to belong exclusively to the province of somatic medicine, which attributed the problems to such things as wandering uteruses (the literal meaning of "hysteria") or the influence of "animal spirits." Finally, the actual ***practice*** of the intentional paradigm has been developed into an applied discipline practiced by trained professionals which is thriving like never before (although there were some analogues in the practices of temple medicine, but these were generalized rituals which were not tailored to the attitudes and problems of the individual sufferers). In fact, its practitioners (clinical psychologists and social workers) are actually starting to outstrip medical psychiatrists in numbers! These developments hardly seem to be the marks of a stagnant or ailing paradigm, and thus it seems to be a serious exaggeration to suggest that the intentional paradigm has been stagnant for millennia, or that it seems ripe for "outright elimination." Thus, despite Churchland's (1988, p. 46) allegation that "folk psychology has enjoyed no significant advances or changes in 2,000 years," then, there have been some staggering developments within the last hundred years alone, and who knows what the future might bring. In fact, it's probably a serious mistake to suppose that intentional psychology sprang full-grown from Zeus like Athena! It's been in the process of growth and refinement for millennia, and will probably continue to be.

Summary: The Failings of the Supporting Arguments for Neuroeliminativism

In his (1988, p. 45), Churchland writes, "The arguments for eliminative materialism are diffuse and less than decisive, but they are stronger than is widely supposed." Perhaps they seem strong when all the supporting arguments are presented together in a kind of smear campaign, but as I have argued, their force is diminished considerably when we take the time to examine them individually; in fact, they don't amount to much at all.

The Churchlands, of course, disagree; their claims, once again, against intentional psychology and in favor of eliminativism, are these:

> Eliminative Materialism is the thesis that our common sense conception of psychological phenomena constitutes a radically false theory, a theory so fundamentally defective that both the principles and the ontology of that theory will eventually be displaced, rather than smoothly reduced, by completed neuroscience. Our mutual understanding and even our introspection may then be reconstituted within the conceptual framework of completed neuroscience, a theory we may expect to be more powerful by far than the common-sense psychology it displaces, and more substantially integrated with the physical sciences generally. (Churchland 1981, p. 67)

While it's true that future neuroscience will no doubt be integrated with the physical sciences (by definition), and it's also true neuropsychology has certain powers (the power to tranquilize

people and produce a number of untoward effects, as we'll see in Chapter Seven), I submit that the evidence we've heard shows that Churchland hasn't given us any good reasons to eliminate intentional psychology even if we *did* have a "completed neuroscience," despite his allegations that intentional psychology is so irreducible, limited, and stagnant as to probably be "radically false."

I spent the least time responding to the irreducibility argument because it was the weakest, given the tenuousness of the assumed connection between a discipline's reducibility and its truth or utility. And because I'll be responding to the claim that intentional psychology isn't of much use when it comes to dealing with abnormal subjects in a good deal more detail in Chapter Eight, I didn't spend too much time on the limitations argument here, either (noting only that we shouldn't expect intentional psychology to explain everything or solve every problem, especially organic problems) so that I could dedicate the most time to the complex historical claim that is most central to the Churchland's position: the assessment that intentional psychology isn't going anywhere, hasn't been for years, and so will probably be swept away like the other theories before it.

At first, I granted that there is a good deal of initial support in the work of the Sophists for the view that at least some of the concepts and principles and practices of folk psychology as it exists today have been around for over two thousand years. However, I saw no reason to be too conciliatory, since there have been indeed been several improvements since that time: the intentional approach has extended its *domain* to include what are now (or were, until fairly recently) called the neuroses; its *theory* has evolved to incorporate unconscious processes and motivations; and, again largely because of Freud's pioneering efforts, the *practice* of applied intentional psychology has been developed into an art in the classical sense (an applied discipline practiced trained professionals), as well. So although Churchland (1988, p. 46) testifies that "folk psychology has enjoyed no significant advances or changes in 2,000 years," there have been some staggering developments in the last hundred years alone, and who knows what the future might bring. Next, I argued that ***even if*** none of this were new and it was all implicit in the Greeks, it doesn't show that intentional psychology is *infertile*, because it might continue to have good results, nevertheless (and indeed it does, as I'll be arguing in Chapter Eight); and it doesn't show it's *false*, either, because the Greeks were so insightful that they just might've got things right, contrary to Churchland's insinuation that it would be miraculous if they did. And to put a little perspective on the debate, I pointed out that it's inaccurate to say that the psychology that first began to flourish with the Greeks was "the very first time" we'd attempted to come to terms with peoples' reasons for behaving, and I also cautioned that if the criterion for being "stagnant" is being continuous with the Greeks' accounts, then the medical model is guilty, too.

So, I do grant that intentional psychology doesn't explain matters such as *how* the brain stores or retrieves representations (although it can often tell us *why* we remember or misremember certain things, but not others), and I will concede for the sake of argument, at least, that folk psychology's theories might "stubbornly" resist *reduction* to more basic sciences (especially if that means having its descriptive and explanatory apparatus be *eliminated* or largely abandoned in favor of the latter's), since that still leaves plenty of work for us all to do. But I do dig my heels in on the third charge: I don't concede for a moment that intentional psychology is so limited a theory that we should eliminate it or think it's false or useless, and I haven't seen any

reason why we should, given the weight of the evidence against Churchland's charges. Of course, the claim that FP isn't useless requires more defense that I have given it here, in the light of Churchland's allegations about it falling short in the domain of mental illness, so I propose that we now put aside these preliminary theoretical concerns about reduction and consilience with other sciences, and get to the real meat of the issue that divides them, namely the understanding and treatment of psychological disorders. After all, society foots the bill for these contrasting approached and reaps their benefits (if any), and if they don't do any work for us, we probably won't bother keeping them around, but if they do, then we probably will, whether or not they're deficient in some of the more abstruse theoretical virtues that have been mentioned; in either case, we will be in a better position to evaluate the eliminativists' predictions or claims, so let's go on to investigate in more detail what applied intentional (i.e., clinical) psychology *can* do for us even in the domain of the so-called mental illnesses, as contrasted to neuropsychology.

Chapter Seven: Intentional and Neurochemical Understandings and Treatments of Depression

Contents

Preamble:

Now let's put all the academic questions about the relative theoretical virtues of intentional psychology and its neuropsychological competition aside, and concentrate upon a far more pressing issue which is all too frequently ignored by the academics; namely, their relative practical worth in understanding and dealing with the actual problem domain confronting them.

Unlike the eliminativists who criticize intentional psychology's limitations and forecast its immanent demise, I come to *praise* content-based psychology, not to bury it. It is not only alive and well, I shall be arguing, but its services are also very much needed, and even *indispensable*. There are, of course, many problems that intentional psychology us with, in areas as diverse as child rearing, education, personnel management, and jurisprudence, but I shall be restricting my attention here to the mental health domain, i.e., to the problem of understanding and treating troubled and miserable people desperately in need of some sort of help, for two important reasons. First and foremost, helping us to cope with disturbances is probably the most vital function that a science of human behavior *should* serve, so far as the community that finances it is concerned, at least, whatever the preferences or opinions of the academics may be. These are, after all, *applied*, clinical disciplines which can affect the health and lives of literally *millions* of people in our society alone with their treatments, as we'll see. Secondly, it is just here that neuroeliminativism makes its deepest challenges to intentional psychology and seems to get its purchase. For both these reasons, we should examine this issue in order to become quite clear on what it is that we're supporting or letting ourselves in for when we cast our lot with one paradigm or the other.

I'll start this review and assessment of the relative merits and prospects of representative forms of clinical psychology and neuropsychology by describing the problem domain and justifying my selection of the treatments to be examined in more detail in Section One, which will also sketch my strategy in defense of intentional psychology and disclose some of the positive evidence crucial to deciding the case against neuroeliminativism.

Introduction to the Problem Domain and the Dispute

For our purposes, there are two main kinds of psychological disorders to consider which applied intentional psychologists and neuropsychologists are called upon to understand and treat: the *less* serious or "minor" neuroses; and the *more* serious ones, such as depression, which the neuropsychological camp calls the "mental illnesses."

In a sense, intentional psychology could probably win the larger dispute with neuroeliminativism right here at the outset, however, on the strength of the former category alone, which includes victims of stress or anxiety disorders such as those considered in Part II. It doesn't require a good deal of argument to establish that such individuals are generally better served by psychotherapy in the long run to help them deal with their inner demons, nightmares, and feelings of inferiority or shame than they are by neuropsychology's sedatives and tranquilizers, and that they probably always will be – given not only the nature of their problems (as we saw in

Part II) and the general effectiveness of psychotherapy (as we shall see shortly), but also especially given the limitations of these types of medication. As I shall argue in detail in Appendix B (since the points are conceded readily enough by neuropsychologists at least in theory, although not frequently enough by physicians in practice), such drugs are only effective in alleviating people's anxiety for a very short term, they impair concentration, autonomy, and ultimate recovery, and they even jeopardize lives, as well; thus, regardless of how it turns out for the so-called "mental illnesses," intentional psychology's clinical services probably aren't going to be eliminated in a troubled (but humane) society. But since this point about the limitations of the minor tranquilizers and sedatives alone would make for a very short discussion of a much larger issue that continues to divide the field, I shall be concentrating on the "mental illnesses" in the text that follows. Even in this domain, I shall be arguing, perhaps *especially* in these cases where people have been afflicted with the most serious kinds of psychological disturbances, intentional psychology's services are often indispensable in helping people come to terms with what is troubling them, contrary to the neuroeliminativist's repeated allegations that folk psychology finds such conditions "almost completely mysterious,"[381] while neuropsychology's rival treatments which have been endorsed as "qualified" successes by neuro-eliminativists such as Churchland (1988, p. 145) tend to impair their patients' autonomy and health. Rather than schizophrenia or manic-depression, however, I shall be focussing on the far more prevalent and arguably the most serious form of these disturbances: *depression*.

"Depression" is defined as "a mood state characterized by a sense of inadequacy, a decrease in reactivity, pessimism, sadness and related symptoms" (Reber 1984, pp. 188-89), while a *major depressive episode* lasts at least two weeks, and is defined as depression,

> ...with all of the classic symptoms of anhedonia ["a general lack of interest in living, in the pleasures of life; a loss of the ability to enjoy things": p. 36] sleep disturbances, lethargy, feelings of worthlessness, despondency, morbid thoughts, and, on occasion, suicide attempts. The term is reserved for cases in which there is no known organic dysfunction."

Other symptoms include: tearfulness, inability to concentrate, restlessness or extreme inactivity, and feelings of emotional numbness.[382] Notice that we are only talking about "simple" or "unipolar" depression here, however, as distinct from "bipolar" or "manic"-depression, which involves episodes of mania, as well.

Depression is both a common and a serious problem: at least 7% of Americans have some degree of depression at any given time, with a little more than 2% having a major episode; while in the neighborhood of 10 to 15% will have at least one major episode in their lifetime. That puts the absolute figures on the *magnitude* of the problem in the tens of millions in America alone, and hundreds of millions the world over.[383] As for its *seriousness*, even if we ignore the misery and suffering of depressives and the friends and families concerned about them, and even if we take

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[381] P.M. Churchland levies the charge that folk psychology finds the major forms of mental illness "almost completely mysterious" in his (1988, p. 46), and makes similar charges in his (1981, p. 73), and in his (1979, p. 114), he says its "grasp of the nature and causes of mental illness is almost nil."

[382] See Monroe (1990, p. E-4); or the DSM-III (1980, pp. 213 ff.).

[383] These figures come from Elkin *et al.* (1985, p. 307) and Rosenhan and Seligman (1984, pp. 320, 351), who cite, among other sources, the 1978 President's Commission on Mental Health Report; Breggin (1983, p. 161); and a one-month prevalence study by Regier *et al.* (1988). Note that the lifetime incidence of the other major forms of mental illness is considerably lower – about 1% each, according to the DSM-III and Regier (1988).

the productivity lost to apathy in stride, depression remains a very serious problem, given that suicidal thoughts and tendencies are part of its clinical profile. Depressed people are twenty-five times more at risk for suicide, and there are upwards of 100,000 suicides a year in the U.S. alone.[384]

Clearly, then, depression is a serious problem, given its extent, its personal and social costs, and its fatal potential, and just as clearly, the condition warrants some sort of treatment. But the question we'll be examining is, "What *kind* of treatment should depressed people be receiving – psychological, somatic, both, or neither?" As we'll see, intentional psychologists believe that the trouble with depressed people is their maladaptive negative attitudes which they need to be persuaded out of, whereas neuropsychologists maintain that they suffer from biochemical *diseases* which can be successfully treated with antidepressant medications. Because it would obviously take too long to review *all* the different forms of pharmacotherapy and psychotherapy that are currently being used to treat depression, however, I'll be focusing on a single representative of each approach: the tricyclic antidepressant imipramine, a prototypical antidepressant which has been widely tested for efficacy and recommended by Churchland (1988, p. 146); and Cognitive Therapy, a type of short-term psychotherapy developed by the psychiatrist Aaron Beck at the University of Pennsylvania which shows excellent prospects of enduring for a long time, because it, too, has proven effective in the treatment of depression, as we'll see, and its central concepts and procedures have now been operationalized and codified in a step-by-step fashion in training manuals,[385] so it can be readily and reliably imparted to future generations of therapists. The Cognitive approach, moreover, is not only successful in treating and in accurately describing the phenomena and phenomenology of depression, I'll be arguing, but it's also a good choice for two pedagogical reasons: it's highly representative of psychotherapy in general, since it incorporates the core elements common to most of the major schools; and yet its terms and methods should be readily recognizable to and respected by a philosophical audience.

The field of dispute, then, is how to cope with depression, and the players are Cognitive Therapy and imipramine. Since I don't wish to leave you in suspense about their current status, however, in the balance of this introductory Section, I will review the latest findings on their efficacy: contrary to many people's expectations, either psychotherapy "works" a lot better than people like Eysenck[386] have led us to believe, or else antidepressants don't "work" nearly so well as their advocates have contended, because they do comparably well, as we'll see. Then, to explain why it would be a serious mistake to try to eliminate intentional psychology from the clinical field, the subsequent Sections will describe and examine the two approaches individually and discuss their indications, side-effects, and potential for abuse. Section Two will subject the therapeutic rationale afforded by the "medical model" of depression to some scrutiny, and go on to detail some of the more common and most likely ineliminable adverse effects and limitations of the antidepressants neuropsychiatry sanctions, to give you a taste of what we would be in for if neuroeliminativism were to succeed in eliminating intentional psychology from the ranks of scientific psychology. Section Three will let the intentional psychologists and Aaron Beck in

[384] The source of this estimate of the extent of suicide is Rosenhan and Seligman (1984), p. 351.

[385] See Elkin *et al.* (1989) for the references for the official training manuals for cognitive therapy and interpersonal therapy that were developed for the purposes of their NIMH study.

[386] Concerning Eysenck's notorious studies, see his 1952 "The Effects of Psychotherapy: An Evaluation."

particular speak for themselves in their own best defense. Finally, in Section Four, I will draw on the preceding best available evidence to support my conclusion that the predictions and prescriptions of neuro-eliminativism are, quite simply, *wrong*.

The Effectiveness of Contemporary Psychotherapy and Pharmacotherapy in the Treatment of Depression

It turns out that, despite all the hype about how well the "mental illnesses" can be controlled by drugs as contrasted to psychotherapy, representative forms of psychotherapy and pharmaco-therapy are comparably effective in abating the symptoms of depression, according to major studies which will be briefly summarized here. As I've mentioned, Cognitive Therapy, the main form of psychotherapy we'll be examining in this Chapter, was developed at the University of Pennsylvania, where the first of these two series of studies took place; we'll start with it, and then discuss the larger-scale National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program.

To begin with, an intensive pilot study by Rush, Beck, Kovaks and Hollon at the University of Pennsylvania in 1977 found cognitive therapy to be *more* effective than imipramine hydro-chloride in the treatment of unipolar depression. That study[387] and its follow up[388] involved 44 mostly white, well-educated, self-referred, chronically depressed patients in their mid-thirties with suicidal thoughts who had achieved poor results with previous psychotherapies, who were administered either imipramine or cognitive therapy twice a week for twelve weeks by relatively inexperienced psychiatric residents. The results strongly favor cognitive therapy, as Rosenhan and Seligman (1984, p. 333) summarize:

> By the end of treatment, both groups had improved according to both the self-report and the therapist ratings of depression. Only one of the nineteen patients assigned to cognitive therapy had dropped out, whereas eight of the twenty-five assigned to the drug therapy had dropped out....Of the cognitive therapy patients, 79 percent showed marked improvement or complete remission, but only 20 percent of the drug patients showed such a strong response. Follow-up at three months, six months, and twelve months after treatment indicated that both groups maintained their improvement. The group that had received cognitive therapy, however, continued to be less depressed than the group that had received drug therapy. In addition, the cognitive group had half the relapse rate of the drug group.

Cognitive therapy had good results with this population – it resulted in significantly greater ($p<.01$) improvements than did the standard antidepressant drug alone, in fact, and a year after treatments ceased, those treated with chemotherapy "had twice the cumulative relapse rate of those treated with cognitive therapy" (Beck *et al.* 1979, pp. 391-92). The basic finding of that preliminary study and its follow-ups – cognitive therapy works at least comparably well as antidepressants do – has been confirmed by the next study, which wasn't confined to its home ground, even though it found that imipramine actually works a little better in the most serious

[387] See Rush, H.A., Beck A.T., Kovacs, M., & Hollon, S. (1977) "Comparative Efficacy of Cognitive Therapy and Pharmacotherapy in the Treatment of Depressed Outpatients," *Cognitive Research and Therapy* 1, 17-37; it is cited and discussed in both Beck *et al.* (1979, pp. 390 ff.) and Rosenhan and Seligman (1984, p. 333).

[388] Kovacs, M., Rush, H.A., Beck A.T., & Hollon, S.D. (1981) "Depressed Outpatient Treatment with Cognitive Therapy or Pharmacotherapy: A One Year Follow-Up," *Archives of General Psychiatry*, 38, 33-39.

cases (although partly because its drug group was receiving supportive therapy concurrently), as we'll see.

Headed by Irene Elkin, the $10 million dollar (Lee 1988, p. 60) NIMH Collaborative study has been a vast undertaking, and isn't yet complete. It involves 28 therapists at three different sites (the University of Pittsburgh, the University of Oklahoma in Oklahoma City; and George Washington University in Washington) and 250 patients, who received one of four different treatments: two forms of brief psychotherapy, Cognitive and Interpersonal; the standard reference antidepressant, imipramine; and a control group, involving a placebo and a lesser degree of psychotherapy or "clinical management." Since imipramine and Cognitive Therapy will be the subjects of extended discussion in Sections Three and Four, respectively, I'll just say a little about the nature of the treatments received by the remaining two groups here before getting to the actual results.

To begin with, the placebo group, which turned out to do better than anyone had expected for the less severely depressed patients, involved not only the familiar sugar pill, but also an attenuated form of psychotherapy they called "Clinical Management" or "CM" sessions, which accompanied both the actual drugs and the placebo. As Elkin *et al.* (1985, p. 311) explain,

> The CM component is intended not only for the purpose of medication management [taking blood levels to determine therapeutic dose, e.g.]. but also to provide a generally supportive atmosphere and to enable the psychiatrist to assess the patient's clinical status. Ideally, the pharmacotherapist provides sufficient support and concern to maintain patient motivation and to achieve patient compliance with the treatment regimen but not to create a significant overlap with the two psychotherapy conditions....The manual and training for this condition include guidelines for providing support and encouragement to the patient and giving direct advice when necessary. The CM component thus approximates a "minimal supportive therapy" condition, and the placebo condition serves as a control both for expectations due to administration of a drug and for contact with a caring, supportive therapist.

Thus, even the (double blind) drug and placebo groups were receiving supportive therapy as well, for twenty to thirty minutes once a week for the entire sixteen weeks of the study, which is a fact of no small significance when evaluating the results, considering that they received fully half the counseling time allotted to the psychotherapy patients, who had up to twenty fifty-minute sessions over the same period (*ibid*., and see Elkin *et al.* 1989, p. 978).

Since Cognitive Therapy will be discussed in detail later, let's turn directly to Interpersonal Therapy (IPT), which was devised by Gerald Klerman and the late Albert DiMascio, based on the dynamic approaches of Freud, Adolph Meyer, and Harry Stack Sullivan. As Elkin *et al.* (1985 pp. 310-11) explain,

> Interpersonal psychotherapy is based on the premise that depression occurs in an interpersonal context. The techniques are intended to help patients achieve a better understanding of their interpersonal problems and to improve their social functioning. The rationale is that if improvement in interpersonal relations can be effected, improvements in other areas will follow.

Following this rationale, IPT is like most other forms of psychotherapy, as Klerman and Weissman (1987, p. 5) note, in that it sets about "helping the patient to develop a sense of mastery, combating social isolation, restoring the patient's feeling of group belonging, and

helping the patient rediscover the meaning in life." As its training manual explains, however, it differs from the classical psychoanalytic approach in being more rooted in the present:

> The nature of IPT is interpersonal – not intrapsychic – with focus on the "here-and-now" rather than on early developmental experiences. The overall goals of treatment are to encourage mastery of current social roles and adaptation to interpersonal situations.
>
> ...interpretation and personality reconstruction are not attempted but rather, reliance is upon familiar techniques such as reassurance, clarification of internal emotional states, improvement of interpersonal communication, and reality testing of perceptions and performance.[389]

Now let's examine the results. Although the preliminary results of the NIMH study were initially released by Elkin at an APA meeting back in May 1986 and were reported by the popular press (e.g., see Gelman *et al.* 1986, Lee 1988), the official results were only published recently (in Nov. 1989), and they're not all in yet, pending an analysis of the six, twelve, and eighteen-month follow-ups. What is known the general effectiveness of the four treatments at the termination of treatment, however, is summarized in the abstract to Elkin *et al.* (1989, p. 971):

> Patients in all treatments showed significant reduction in depressive symptoms and improvement in functioning over the course of treatment. There was a consistent ordering of treatments at termination, with imipramine plus clinical management generally doing best, placebo plus clinical management worst, and the two psychotherapies in between but generally closer to imipramine plus clinical management. In analyses carried out on the total samples without regard to initial severity of illness (the primary analyses), there was no evidence of greater effectiveness of one of the psychotherapies as compared with the other and no evidence that either of the psychotherapies was significantly less effective than the standard reference treatment, imipramine plus clinical management.
>
> ...Significant differences among treatments were present only for the subgroup of patients who were more severely depressed and functionally impaired; here, there was some evidence of the effectiveness of interpersonal psychotherapy with these patients and strong evidence of the effectiveness of imipramine plus clinical management. In contrast, there were no significant differences among treatments, including placebo plus clinical management, for the less severely depressed and functionally impaired patients.

According to one of the primary measurements they used, the Hamilton Rating Scale for Depression (HRSD), the *recovery* rate for the three non-placebo groups was around forty percent of those who completed treatment, which roughly doubled that of the placebo group;[390] although this rate in turn halves that of the earlier study, this is because "recovery" is a far more stringent standard than "marked improvement." At any rate, the bottom line is that representative forms of pharmacotherapy and psychotherapy do roughly as well in treating depression; as Elkin *et al.* (1989, p. 980) put it in their conclusion, "it is clear that there is no evidence of greater effectiveness of one of the psychotherapies as compared with the other and no evidence that either of the psychotherapies was significantly less effective than the standard reference treatment." (At least, not "In the set of findings for the total unstratified sample of patients in our primary analyses;" I shall address the problem of the most serious cases in Section 7.4.2.2.)

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[389] Klerman and Weissman's preliminary (1979) IPT manual is quoted in Elkin *et al.* (1985), p. 311. It is now out in book form: *Interpersonal Psychotherapy of Depression* (New York: Basic Books, 1984) by GL Klerman, MM Weissman, BJ Rounsaville, and ES Chevron.

[390] See Elkin *et al.* (1989, p. 975): "The percentages of patients entering treatment who reached the HRSD recovery criterion were 43% and 42% for IPT and imipramine-CM, respectively, and 21% for [placebo]-CM. Patients receiving [Cognitive Therapy] had a recovery rate of 36%, not significantly worse that that with IPT and imipramine-CM, though also not significantly better than that with PLA-CM."

We know going into the dispute, then, that it's probably going to come out a tie, since *both* approaches have their uses, and ultimately that's the verdict I'll recommend we should all draw; but since this is a defense of the intentional approach, I'm going to proceed to emphasize the medical model's weaknesses and play up the intentional approach's strengths. The other side has no shortage of advocates of its own, after all, so let's go on to consider the therapeutic rationales and side-effects of the primary pharmacological and psychological treatments of depression, starting with the former.

The Contender: NeuroEliminativism and Applied NeuroPsychiatry

As we have just seen from these preliminary results, which show that some of its drug treatments seem to do a little better than psychotherapy can, at least in the more serious cases, neuropsychiatry is certainly a serious contender for being able to someday eliminate the services of intentional psychology, if any field is.

Neuropsychiatry, the applied extension of neuropsychology, currently has two main weapons in its therapeutic armamentarium:[391] shock- or electro-convulsive "therapy"; and drug- or "pharmaco"-therapy. However, since neuroeliminativists don't take a stand on the former's merits, I won't be saying much about ECT until Section 7.4.2.2 (when I take up the question of what to do about acutely suicidal subjects), apart from simply noting here that even its fondest admirers still haven't the foggiest notion why a jolt to the head *should* be of help,[392] aside from the obvious fact that it makes people forget their troubles at least temporarily. For the moment, then, let's concentrate on the kinds of theoretical models and psychotropic drugs which *are* advocated by neuroeliminativists.

I will start by letting P.M. Churchland introduce and describe what's widely known as "the medical model of mental illness," which serves as the rationale behind drug therapy. Then I'll draw upon the psychiatric literature to elaborate upon this model and examine its lack of evidence concerning the presumed neurochemical causes of depression. After dispensing with the theories about how neuropsychology's drugs are *'supposed* to work, I'll go on to describe how they *do* work, particularly how they produce side-effects, including the very sorts of bio-chemically induced mental disturbances they're supposedly controlling or curing.

The Rationale Behind Pharmacotherapy

The drug rationale that underwrites pharmacological treatments of mental disorders is well articulated here by P.M. Churchland (1988, pp. 145-46):

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[391] The somewhat militaristic expression "therapeutic armamentarium" is culled from the neuropsychiatric literature itself, I assure you.

[392] Of course, there are a number of *hypotheses* about how convulsive therapy works, whose weaknesses are reviewed in a Symposium by Max Fink and others (in *Neuropsychopharmacology* vol. 3, no. 2, 1990) but as Harold Sackeim and D.P. Devanand note in their commentary, "Why We Do Not Know How Convulsive Therapy Works" (in the same issue, p. 83): "Despite 50 years of investigation, it is not known how electroconvulsive therapy (ECT) works"

> ...extreme doses of certain of the psychoactive drugs produce symptoms that closely resemble those of the major forms of mental illness – depression, mania, and schizophrenia. This suggests the hypothesis that these illnesses, as they occur naturally, involve the same neurochemical abnormality as is artificially produced by these drugs ...[and] may well be correctable or controllable by a drug with an exactly opposite neurochemical effect. And thus it seems to be, though the situation is complex and the details are confusing. *Imipramine* controls depression, *lithium* controls mania, and chlorp*r*omazine controls schizophrenia. Imperfectly, it must be said, but the qualified success of these drugs lends strong support to the view that the victims of mental illness are the victims primarily of sheer chemical circumstance, whose origins are more metabolic and biological than they are social or psychological....If we can discover the nature and origins of the complex chemical imbalances that underlie the major forms of mental illness, we may be able to cure them outright or even prevent their occurrence entirely.

Judging by this passage, which refers to "mental illnesses" as "naturally" occurring chemical imbalances, the medical or disease model of depression ignores such diverse environmental and social pressures confronting troubled and disturbed subjects as becoming old and being cast off by one's employers and family, or being discriminated against, or being abandoned, hurt or abused by a loved one, and other life-situations that can make people feel unworthy and hopeless, and it suggests furthermore that simply taking a pill can fix all the difficulties we have in dealing with the world.

But have any of these alleged bio-chemical imbalances been identified? Neuroscientists have implicated a number of candidates, but the *current* reigning hypothesis concerning unipolar depression in particular is that it involves a deficiency in the relative levels or activities of certain endogenous stimulants in the brain called the *amines*. Investigators have been led to this conclusion by the observation that tric-cyclic anti-depressants such as imipr*amine* and also Mono-*Amine* Oxidase Inhibitors (MAOI's) both end up increasing the active levels of the neurotransmitters norepinephrine or noradrenaline, and serotonin.[393]

That's the rationale, then – depressed peoples' brains need increased stimulation – but does it hold up? The problem is, this therapeutic rationale is based on strictly *post facto* reasoning: judging the nature of the ailment from the effects of the very treatment whose use it is attempting to legitimize. This sort of ***Post**-hoc* reasoning is a two-edged sword, however, because it can also be used to cut in intentional psychology's favor, since by parity of reasoning, depression is probably a sheerly psychological problem, not a neurochemical one, given psychotherapy's comparable success in treating it. As we suspect from that antinomy, we are dealing with a dubious inference, here, and so we are, for several reasons.

First, just because certain chemicals produce changes in our systems when we ingest them doesn't mean that there was something wrong with our chemistry in the first place. After all, alcohol produces a host of changes in us, too, but we're not tempted to judge on that basis that

[393] See, e.g., Law and Foltz (1990, pp. 176, 181); or Reber (1984, p. 791) who explains that tricyclic compounds "function by preventing the reuptake of amines in cholinergic synapses. The resulting increases in these stimulants is apparently the basis for their antidepressant effects. A host of these compounds is in use although the 'parent' drug *imipramine* is the most commonly prescribed."

it's likely to *cure* anything;[394] at best it can be used to stave off problems, many of which are induced by it in the first place.

Second, even if we independently established that depressed people have a relative preponderance or deficiency of some neurochemical activity , that still wouldn't tell us whether these biochemical imbalances were the *cause* of their depression or a concomitant *result* of their altered thoughts, plans, expectations, and so on (cf. psychosomatic ailments induced by feelings of guilt or worry), in which case inducing further changes even in an attempt to compensate might be apt to trigger a vicious cycle of over-production of other neurotransmitters as the body attempts to restore its homeostasis. As we're about to see, that seems to be the case with neuropsychology's neuroleptic drugs.

Third, and perhaps most importantly, when we go further and proceed to check the inference against the facts to see whether there is any independent evidence for the view that depression is caused by a problem in the concentration of certain neurotransmitters apart from the effects of antidepressants, the medical model doesn't fare well. Although there have been extensive and repeated tests, the direct evidence for "the amine hypothesis" is quite insubstantial. The way to find direct evidence for the amine hypothesis is to test *un*treated depressed subjects for neuro-chemical abnormalities, and hosts of neuroscientists have been doing this for some time, spurred on by pharmaceutical company and government money, but they've yet to get the hard evidence in their favor – the alleged abnormalities haven't been found, at least not consistently.[395]

Fourth, and finally: not only is there still a lack of substantial evidence to back up the therapeutic rationales of the major psychopharmacological treatments of mental "illnesses," but they also seem to break down completely when you check them against the actual practices they are papering over. On this view, mental illnesses involve a single dimension – a relative excess or deficit of neural inhibition or stimulation. Depression supposedly involves a deficit of neural activation, while schizophrenia is thought to involve *too much* dopamine (a precursor to the stimulants norepinephrine or noradrenaline and epinephrine or adrenaline), while the bipolar disorder involves fluctuations from one end of the scale to the other. So far, so good, I suppose, but if we are to proceed to treat these alleged imbalances with potent drugs, it would be reasonable to expect the drugs treating the different disorders to *be* different. However, it turns out that there is very little pharmacological difference between paradigmatic members of the supposedly distinct classes of drugs, the anti-depressants and anti-psychotics. As Breggin (1983, p. 166) explains, this poses a serious problem for "one of the powerful and sustaining myths in modern psychiatry ... the idea that psychiatry is developing specific drugs for specific illnesses":

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[394] This point is made by Peter Breggin – a prominent critic of the excesses and hazards of neuropsychiatry's treatments to whom this Chapter greatly indebted – in his (1983, pp. 3, 65).

[395] See Breggin (1983, pp. 182-183), or consult any contemporary neuropsychiatry or pharmacology textbook such as Brown and Wallace (1980, pp. 281 ff.), which still refer to it as the amine *hypothesis* since it hasn't been corroborated. Or see Kalat (1984, p. 409): "Direct measurements of norepinephrine and serotonin metabolites in the urine and cerebrospinal fluid (CSF) indicated enormous variations among depressed people," citing M. Asberg, P. Thoren, L. Traskman, L. Bertilsson, & V. Ringberger, "'Serotonin Depression' – A Biochemical Subgroup Within the Affective Disorders?" (*Science* 191, 1976, pp. 478-480), and A.F. Schatzberg, P.J. Orsulak, A.H. Rosenbaum, T. Maruta, E.R. Kruger, J.O. Cole, & J.J. Schildkraut, "Toward a Biochemical Classification of Depressive Disorders, V: Heterogeneity of Unipolar Depressions" (*American Journal of Psychiatry*, 139, 1982, 471-75).

> ...tricyclic antidepressants... are...called tricyclic [b]ecause their chemical nucleus has the basic tricyclic structure of the original phenothiazine major tranquilizer (chlorpromazine, trade name Thorazine). The only structural difference between chlorpromazine, the most commonly used major tranquilizer, and imipramine, one of the most commonly used antidepressants, is the replacement of a sulfur atom with a carbon chain in the bridge between benzyl rings in the phenothiazine nucleus. Variations in chemical structure among the major tranquilizers are greater than those between chlorpromazine and imipramine. The most relied-on antidepressant, then, is an exceedingly neurotoxic variation on the major tranquilizers.

Thus, imipramine, the so-called "anti-depressant" is scarcely different from its supposed opposite, chlorpromazine, an "anti-psychotic," which puts both their rationales into question. But since the primary directive of medicine is to *heal*, after all, not to explain, let's go on to consider those neurotoxic effects Breggin just mentioned. Although I believe that the psychological theories concerning the factors that sustain depression which will be discussed in due course have more merit than the neurophysiological theories have alone, the issue that should ultimately decide this particular policy dispute is *whether* and *how* well the treatments work, rather than *why*. Since that should probably suit the pragmatically inclined eliminativists fine, let's get straight to the effects of neuropsychiatric drugs, in order to understand why their success must be highly "qualified" indeed.

The Hazards of Anti-Depressants

Although advocates praise them as safe and effective, it should be known that anti-depressants have many side-effects and hazards. Some of these adverse effects are regarded by the physicians administering the drugs as "minor," although they can be quite damaging to depressed people's already impaired self-esteem, while others pose serious threats to people's physical health and even prove fatal. Since we obviously don't have time to get into *all* the antidepressants in detail, we'll concentrate on the drug P.M. Churchland mentioned, imipramine (the prototypical tricyclic whose efficacy has been widely established). I will be discussing some of the other kinds, as well, but let's start by reviewing imipramine's three main groups of adverse effects: cardiovascular, autonomic, and central nervous system effects.

We'll start with the most prevalent cluster of symptoms, which are called *anti*-cholinergic" effects because they're the results of the drugs' antagonism of the *cholinergic* neurons and neural pathways, which release acetylcholine as their neurotransmitter. Cholinergic neurons are involved extensively in the sympathetic and parasympathetic fibers that control our autonomic system.[396] As you might expect, when they are interfered with, a variety of untoward effects are frequently produced: dry mouth (which can lead to infections and cavities); constipation or diarrhea; indigestion; urine retention; and nausea.[397]

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[396] E.g., see Reber (1984, p. 120), which notes that the cholinergic fibers "include all preganglionic fibers, all postganglionic parasympathetic fibers and those postganglionic sympathetic fibers that innervate the sweat glands and efferent fibers to skeletal muscle."

[397] For this familiar list of anticholinergic effects, see, e.g., Edelstein (1980, pp. 26 ff.), or Schoonover (1983, p. 48); or Griffith (1988, pp. 996-97).

Obviously, some of these symptoms can prove to be major inconveniences, and some, such as weight gain of up to twenty pounds, can be quite damaging to one's self-esteem in societies such as ours. And related effects, which include sexual problems such as inducing painful or heavy menstruation (see Griffith 1989, p. 996), or reduced libido and delayed or difficult orgasms *and* swollen breasts in both sexes,[398] or "Pathological" sweating (which occurs in approximately 25% of patients, according to Schoonover 1983, p. 49) can also be serious impediments to depressed subjects' social lives.

But these autonomic effects are just the beginning. Now let's turn to the cardiovascular effects, which are manifested in a number of fatal overdoses each year.[399] These fatalities occur not only as the result of deliberate over-doses on the part of suicidal patients, which is a serious problem I'll be discussing later on, but also at the so-called "therapeutic" levels that doctors prescribe. As Edelstein (1980, p. 23) explains for us here, given antidepressants' stimulative effects, such dangerous cardiovascular symptoms as severe palpitations, arrythymias, and full-fledged heart attacks are to be expected:

> Many of the adverse effects of tricyclic antidepressants will be a result of the accumulation of noradrenaline, which will exert an excessive influence at the adrenergic synapses and in the body as a whole.
>
> Inhibition of the uptake of noradrenaline will deplete the myocardium and lead to a high concentration of circulating catecholamines. This, together with the anti-cholinergic and quinidine-like effects of the tricyclic drugs, will produce disturbances of cardiac rate, rhythm and conduction, which may be frequent in patients with hypertension and/or myocardial insufficiency.
>
> With excessive doses these reactions may be intensified and lead to life-threatening arrythymias, conduction disturbances and cardiorespiratory depression with hypotension and even complete heart block. ...Doses in excess of 1 g are seriously toxic [normal therapeutic dose is from 50-300 mg/day] and with 2 g or more fatalities are fairly common.[400]

In addition to their cardio-toxicity, anti-depressants prove fatal in other ways, too. Like most psychiatric drugs, they are metabolized primarily by our livers, which puts a heavy burden on them and can lead to jaundice and fatal hepatitis, albeit very rarely.[401] There's also a more subtle

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[398] See Edelstein (1980, p. 27); Griffith (1988, p. 996); or Shader and DiMascio (1970) concerning the sexual side-effects of antidepressants such as delayed orgasm or impotence. As Richard Shader reports in "Male Sexual Function," (in DiMascio and Shader (1970), p. 63), the failure to ejaculate may be "the result of central sympathetic (hypothalamic) depression and peripheral adrenergic blockade," but in some cases it is due to "retrograde ejaculation," as he explains in "Ejaculation Disorders" (*op. cit*., 72 ff.): instead of being ejaculated, the sperm is directed to the bladder and eventually expelled as "white urine." This might be good birth control, but it can be painful as hell (see Kotin *et al.* (1976), reported in Breggin (1983), pp. 50-51).

[399] While I don't yet know the absolute figures, Breggin (1983, p. 180) reports, "In 1979 the most commonly prescribed antidepressant, Elavil, ranked near the top as a cause of drug-related death (Hughes & Brewin, 1979 *The Tranquilizing of America*. New York, Harcourt, Brace, Jovanovich.). A more recent report (*Clinical Psychiatry News*, [Oct. 1981, p. 1]) indicates that the major antidepressants are overtaking the barbiturates as the medications most frequently involved in serious overdose."

[400] Cf. Ebert and Shader (1970, p. 157) who inform us, "A number of cases of arrhythmias, often fatal, following imipramine overdosage, have been reported," while Schoonover (1983, p. 42) records that people with cardiac conditions have a "significantly increased risk of complications" – "complications" such as *sudden death*; this is corroborated by Edelstein (1980, pp. 23-24).

[401] See Schoonover (1983, p. 40); or Michael Ebert and Richard Shader, "Hematological Effects," in Shader and DiMascio (1970, pp. 164-69); or Edelstein (1980, p. 26) about hepatitis. For a ball-park figure about the incidence of jaundice, Davis (1985, p. 1510) reports that between 1 in 200 and 1 in 1,000 experience an extreme allergic reaction to chlorpromazine and develop jaundice; and as we'll see in the text, imipramine is closely related to chlorpromazine.

means of death, agranulocytosis – an AIDS-like blood condition involving a depletion of white cells and a resultant susceptibility to infection.[402] Its incidence is fairly rare (in the neighborhood of 1 per three or four thousand patients treated[403]), but it is fatal in 60% of the cases (Edelstein 1980, p. 26). Finally, tricyclics lower the seizure threshold.[404] Seizures can be fatal (especially when people have been eating, because they can gag on their food and asphyxiate),[405] and persistent seizures can lead to permanent brain damage.[406]

In addition to the manifestly lethal effects of anti-depressants, even their so-called "minor" side-effects can sometimes lead to fatal complications. To start with, like many psychiatric drugs, they induce postural hypotension, an abrupt drop in blood pressure upon rising suddenly.[407] This effect is very frequent with imipramine, occurring in up to half the cases,[408] and it often results in people fainting, thus posing a serious risk to the elderly, who have far more brittle bones and are apt to catch fatal pneumonia if they fall and break something. Furthermore, as Schoonover (1983, p. 49) reports, even uncomfortable autonomic effects such as constipation or urine retention can escalate far beyond mere inconveniences: "Urinary retention also may cause severe problems. Some patients have died from acute renal failure following the development of an atonic bladder." As Breggin (1983, pp. 180-81) notes, given the hazards posed by urinary retention, it is particularly regrettable that these very drugs are prescribed to children to help curtail bed-wetting by impairing their urinary functions.[409]

Now let's turn to the CNS and neurological side-effects of these drugs, such as sedation, poor motor coordination, and difficulty in concentrating. Unlike the symptoms we've looked at so far, these were originally intended by the designers of the drug's predecessor, as we'll see. Let's start by putting aside the physical side-effects of these drugs for the moment, and turn to their psychological effects.

The Psychological Effects of Anti-Depressants

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[402] "Agranulocytosis" is defined by *Stedman's* as "An acute condition characterized by leukopenia with great reduction in the number of polymorphonuclear leukocytes; infected ulcers are likely to develop in mucous membranes and in the skin." "Leukopenia" means that there are fewer white cells in the blood, so there is a greater susceptibility to infection.

[403] The incidence of agranulocytosis is reported to be in the neighborhood of 1 per three or four thousand patients treated in a number of places, e.g., Gelenberg (1983, pp. 148-49).

[404] The fact that tricyclics lower the seizure threshold in reported in, e.g., Griffith (1989, p. 996), or Law & Foltz (1990, p. 183).

[405] See Frederick Zugibe, "Sudden Death Related to the Use of Psychotropic Drugs," in *Legal Medicine*, 1980, Ed Wecht CH (Philadelphia, W.B. Saunders), cited in Breggin (1983, pp. 71-72).

[406] Thanks to Dr. Sonia Huntley for pointing out the dangers of persistent seizures to me and for suggesting a number of other revisions to this Chapter.

[407] Hypotension is a common effect of antidepressants; see, e.g., Schoonover (1983, p. 34); Georgatos and McCue (1986, p. 374); or Lazarus (1979, p. 20).

[408] Schoonover (1983, p. 42), or Michael Ebert and Richard Shader, "Cardiovascular Effects," in Shader and DiMascio (1970, p. 153) report that antidepressants cause hypotension in up to half of the patient population.

[409] The practice of prescribing tricyclics to children to curb enuresis continues this day – see Griffith (1989, pp. 996-97), or Law and Foltz (1990, p. 181).

Studies show that antidepressants "work" in the sense that they dispel at least some of the symptoms of depression in some cases. Maybe only 43% ***recover***, as the NIMH has found, but a number of neuropsychologists have claimed that there's significant *improvement* in at least two out of every three cases[410] (cases in which the patients actually comply with the treatment, that is – a point I'll return to later). But what sort of improvements are these, and which symptoms are being relieved – just the so-called vegetative ones, such as insomnia and weight loss, or the psychological ones, as well? What *are* the psychological effects of anti-depressants such as imipramine? As we'll now see, antidepressants often don't work well at all, because although they can induce drowsiness and weight gain in our bodies, they may seriously impair the *person* behind the symptoms, since they may dull concentration and awareness and make it difficult to speak, and even make us psychotic in somewhat larger doses. Let's get the problem with large doses out of the way first, and then spend a little more time on the psychological effects of *normal* dosage levels, which are all the more insidious, since they are considered "therapeutic."

As if the lethal and discomfiting physical effects we've heard about so far were not enough, there's yet another problem with neuropsychiatry's approach to psychological problems: it becomes a self-fulfilling prophesy, because its drugs sometimes "paradoxically" produce the very sorts of biochemically induced abnormalities that they're supposed to be "curing" or "controlling." Schoonover (1983, p. 47), for example, reports,

> Sometimes heterocyclic administration may produce paradoxical reactions. These drugs may cause marked increases in anxiety and worsening of some depressions, particularly mild depressions. They may also produce insomnia and nightmares. Heterocyclics can also induce paradoxical mania in predisposed patients and may cause psychotic reactions or confusional states with delusions, hallucinations, and disorientation both in patients with underlying psychotic disorders and in "normal" individuals.

These psychotic symptoms are only "paradoxical" relative to pharmacotherapists' intentions, however, because their occurrence is neither rare nor inexplicable. It's perfectly understandable how they arise – they're signs of central anticholinergic toxicity (see, e.g., Georgotas and McCue 1986, pp. 373-74), and as such they've even got a name: the "anticholinergic syndrome," which Schoonover (1983, p. 53) describes:

> In its florid state, the CNS picture consists of confusion, delirium with disorientation, agitation, visual and auditory hallucinations, anxiety, motor restlessness, pseudoseizures (myoclonic jerks and choreoathetoid movements with EEG seizure activity), and a thought disorder (e.g. delusions).

The estimate of the incidence of the anticholinergic syndrome in patients on tricyclics ranges from between 5% for users in general,[411] to as many as one out of every three older patients, who are afflicted with "acute organic brain syndromes" (whose symptoms include "involve global impairment or loss of the highest human faculties, including orientation, memory, emotional stability, judgment, and intelligence;" Breggin 1983, p. 78), as we can see from this passage from Breggin (1983, p. 172), which summarizes and quotes a Yale study by Davies *et al.*:[412]

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[410] E.g., see Georgatos and McCue (1986, p. 371): "Tricyclics have been the most widely used antidepressants with a response rate around 60 to 70 percent depending on the study design and selection criteria."

[411] E.g., see Ray (1983, pp. 284): "tricyclics can cause severe side effects: about one user in 20 will have disorientation, hallucinations, or other anti-cholinergic effects."

[412] RK Davies, GJ Tucker, M Harrow, and TP Detre, "Confusional Episodes and Anti-Depressant Medication," *American Journal of Psychiatry*, 128, 1971, pp. 95-99.

> In a review of 150 charts [they found that 13 percent of the total sample and 35 percent of those over 40 years of age (the age group most frequently given antidepressants) experienced acute organic brain syndromes during routine treatment on a hospital ward:
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> > The majority of episodes began with evening restlessness and pacing, followed by sleep disturbance (usually middle-of-the-night awakening). This progressed to forgetfulness, agitation, illogical thoughts, disorientation, increased insomnia, and, at times, delusional states. The average episode lasted a week, with a range of three to 20 days.
> >
> > ...The changes seemed to occur two to four weeks following the administration of the drug. Since this period coincides with the usual onset of clinical effectiveness, it seems reasonable that the confusional episodes are expressions of biochemical events indicative of changed brain functioning, rather than being primarily psychologic in nature.

Further evidence that the drugs were causing the confusional episodes was the fact that the patients all responded rapidly to the withdrawal of the drug.[413] In short, antidepressants are intoxicating, but not enjoyable, because they don't cause euphoria. Unlike users of recreational drugs, depressed "patients" are not in control of the situation, and the fact that there's no black market in antidepressants and antipsychotics indicates that potential users don't find them inherently desirable, as Breggin (1983, p. 6) notes. One reason for this is that they can make people feel so uncomfortable and restless, as Edelstein (1980, p. 26) reports:

> Unusual psychiatric or neurological reactions have several times been observed, generally where mixtures of drugs (often including maprolitine) have been given. The symptoms comprised ataxia ["incoordination, inability to coordinate the muscles in voluntary movement"], akathisia ["an inability to remain in a sitting posture, with motor restlessness and a feeling of muscular quivering"], hypokinetic [slow moving] disorders of speech and motion, a 'dream state' and transient derangement of memory.

Perhaps these sorts of symptoms are best understood by comparing them to a syndrome that some of you may be more familiar with which it resembles closely: the DT's, or *delerium tremens*, which *Stedman's Medical Dictionary* defines as "a form of acute insanity due to alcoholic withdrawal and marked by sweating, tremor, atonic dyspepsia [poor digestion], restlessness, anxiety, precordial distress [heartburn], mental confusion, and hallucinations." Words like "akathisia" cloak the reality – the drugs sometimes make people feel so jittery that they can't even sit through a dinner hour or a movie, and reading is out of the question (see van Putten 1975, p. 71). As Breggin (1983, *passim*, esp. p. 175) comments, behavioristically oriented doctors are probably mistaking the discomforting hyperactivity, acute agitation and restlessness that can be produced by these drugs as *therapeutic* effects, considering the patients' former apathy, and thus neuropsychologist's current therapies may simply be variations of their earlier practice of administering amphetamines to speed up sluggish patients, and barbiturates to calm down agitated ones.

But enough about the "paradoxical" reactions of antidepressants and the agitation they induce in high doses; now let's turn to the psychological effects that occur even at the "therapeutic" levels. To understand these effects, we must begin by going back about thirty years, to recall how and

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[413] E.g., see Edelstein (1980, p. 127) who reports on the same study cited in the last note: "Confusional reactions were observed in 13% of 150 patients being treated with tricyclic drugs, occurring in as many as 35% of patients over 40 years of age. All responded rapidly to the withdrawal of the drug." See Breggin (1983, p. 166) quoted above, or Swazey (1974, p. 193) concerning imipramine's lineage as a direct spin-off of CPZ.

why they were developed in the first place. Most of the drugs in psychiatry's arsenal since the 50's "pharmacological revolution" are spin-offs from the prototypical antipsychotic chlorpromazine or CPZ (trade-name Thorazine in the U.S.) which Churchland (1988, p. 146) also sanctions, and this is especially true in imipramine's case. To understand the pervasive "therapeutic" effects we'll be looking at, it is well worth noting that neuropsychiatry calls potent drugs such as CPZ "*neuroleptics*," while "*neuroleptic syndrome*" designates the types of changes they are capable of producing even at prescribed doses, and sometimes they can induce the "*Neuroleptic Malignant Syndrome*." As we'll see, imipramine probably isn't sufficiently like CPZ to cause the last of these (although its withdrawal was implicated in one lethal case: see Merriam 1987), but it can induce the less-than-malignant neuroleptic syndrome, so let's dip into the history and go over these three expressions in turn.

Although many take "neuroleptics" to be synonymous with "antipsychotics," this is a mistake, because according to *Stedman's*, "*neuroleptic*" denotes an agent "producing analgesia, sedation, and tranquilization or a condition similar," and not all antipsychotics produce sedation (since some are actually stimulants: see Davis 1985, p. 1485), and not all neuroleptics are administered to psychotics. Jean Delay, one of the first French investigators to see CPZ in action on humans, coined the term because its neuro-chemical mechanism is so fundamental that it grasps or "takes hold of" (the English rendering of the Greek *lepsis*) the individual neuron. Delay and his colleague Pierre Deniker also christened the expression "*the neuroleptic syndrome*" to describe these drugs' characteristic effects.[414] I'll cite some of these early reports now, because they are far more frank about the true limitations and effects of the drugs than psychiatrists tend to be today. Psychopharmacology was just starting out as a discipline unto itself then with the development of these very drugs, and although psychiatrists were using sedatives, restraints, wetpacks, insulin shock, psychosurgery, and/or psychoanalysis, they didn't have such a vested interest in suppres-sing the limitations of drugs as they do now, with the advent of its non-medical competition, the field of clinical psychology.[415] When we turn to these early reports, we find the key to under-standing these drugs' so-called "therapeutic" effects *isn't* that they improve people's mood by giving them more positive outlooks or reducing their pain; rather, they just make them more *indifferent*, so they're relatively less bothered by things, but they're far from being "cured."

Delay and Deniker's first description of the neuroleptic syndrome was read to the 50th French Congress of Psychiatry and Neurology in 1952,[416] and as Swazey (1974, p. 134) puts it, their report began by depicting "three characteristic phases of a patient's response to CPZ – a profile that would soon be seen in several million additional CPZ recipients around the world." These

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[414] See Jean Delay and Pierre Deniker (1955) "Neuroleptic Effects of Chlorpromazine in Therapeutics of Neuropsychiatry." *Int. Rec. Gen. Med. Pract. Clin*. 168: 318-26.

[415] The fact that it is the ability to prescribe drugs that most differentiates psychiatrists from the clinical psychologists with whom they compete for the more affluent customers is pointed out by Breggin (1983, pp. 259-62) and also by Brian Yates and Frederick Newman, "Approaches to Cost-Effectiveness Analysis and Cost-Benefit Analysis of Psychotherapy," in VandenBos (1980, esp. pp. 203-205.

[416] See Delay and Deniker (1952a) "Le traitement de psychoses par une methode neurolytique derivee de l'hibernotherapie. (Le 4560 R.P. utilise seul. En cure prolongee et continue.)" *C. R. Congres Med. Alien. Neurol. France* 50: 497-502; and their (1952b) "38 Cas de psychoses traite par la cure prolongee et continue de 4560 R.P." *C. R. Congres Med. Alien. Neurol. France* 50: 503-13.

three phases correspond to the *beginning* of treatment, *while* it's taking full effect, and *after* it's withdrawn.

Let's begin with the final phase, since it's the least problematic. In the *post*-therapeutic phase, when neuroleptic treatment ceases, subjects hopefully return to normal. As Delay and Deniker note,[417] "this happens only *several* days after the cessation of treatment, when the patient, if he has been pale, recovers his color and activity and his normal 'spirit';" if this *doesn't* happen, they don't hesitate to recommend putting the patient back on the drug, which is unfortunate, considering what happens to people's "spirit" while they're under the drugs' influence in the other phases, so let's consider them now.

In the *initial* phase, neuroleptics are capable of producing extreme drowsiness and sedation. This is hardly surprising, since they originated as a type of antihistamine in France designed by Henri Laborit to artificially induce hibernation in patients recovering from the shock of major surgery.[418] Ultimately, they fail as sedatives, however, because our bodies develop a tolerance to them after the first two to three days of treatment, although sometimes the sedation can last for eight to ten days. However, although neuroleptics generally technically cease to act as *sedatives* after a short while, they can continue to function as ***tranquilizers***. The distinction between the two may be somewhat elusive, as Tushnet notes,[419] but the main difference seems to be that patients don't have as much trouble actually staying *awake* on tranquilizers, but most people can still never quite shake off the lethargy, drowsiness, and impaired concentration and hand-eye co-ordination that drugs of both kinds can induce, which is why psychopharmacologists such as Schoonover (1983, p. 44) explicitly caution doctors prescribing psychotropic drugs such as tricyclics to warn the patient about such effects, "if he is in a setting where active physical or mental performance is required" (and that includes just about everyone, considering the hazards of driving or operating machinery under their influence).

But even worse than the first phase's sedation and drowsiness is the *second* characteristic phase, which produces the "psychic syndrome" of ***indifference***. As Delay and Deniker (1952b) report,

> When somnolence disappears, the patient appears at first sight to be normally awake; in reality, he is in a characteristic psychic state, which is practically never omitted, even if the somnolence phase has not taken place.
>
> Seated or lying down, the patient is motionless on his bed, often pale and with lowered eyelids. He remains silent most of the time. If questioned, he responds after a delay, slowly, in an indifferent monotone, expressing himself with few words and quickly becoming mute. Without exception, the response is generally valid and pertinent, showing that the subject is capable of attention and of reflection. But he rarely takes the initiative of asking a question; he does not express his preoccupations, desires, or preferences. He is usually conscious of the amelerioration brought on by the

[417] Delay and Deniker 1952b (see last note), p. 504; translated in Swazey (1974, p. 135).

[418] See Swazey 1974, passim, or Rosenblatt and Dodson (1981, pp. 28-31) on how Henri Laborit developed "4560 RP" or CPZ (chlorpromazine) for the purpose of artificial hibernation.

[419] See Tushnet (1971, pp. 199-200), which provides some interesting background for the expression ‘tranquilizer.’ “This word, formerly rarely used except as slang for a billyclub or a blackjack, came into the general vocabulary as the result of the influence of advertising agencies. *Tranquilizer* is supposed to mean a substance that makes people calm, as opposed to *sedative*, which quiets them.” Tushnet immediately adds, "This distinction is nebulous," and *Stedman's Medical Dictionary* apparently concurs, since it defines "tranquilizer" as "A drug that brings tranquility by calming, soothing, quieting, or pacifying without depression," while "sedative" is defined as, "Calming; quieting."

> treatment, but he does not express euphoria. The apparent indifference or the delay of the response to external stimuli, the emotional and affective neutrality, the decrease in both initiative and preoccupation without alteration in the conscious awareness or in intellectual faculties constitute the psychic syndrome due to the treatment.
>
> The patient comes out of this state at intervals, just as he emerged from somnolence, and one can then see the symptoms of the presenting disease: irony or causticness in the manic, sadness in the melancholy, dysmnesia in the confused. The symptomatology is not masked by the action of the drug and can easily be followed clinically. (translated from Delay and Deniker 1952b, pp. 503-504, by Swazey 1974, pp. 134-35)

As they indicate, the underlying symptoms of the disorder don't really disappear, they just have less influence because the drugged patients become more indifferent to them. Similarly, Sigwald and Bouttier comment on its ability to produce a dissociation between the persistence of painful sensations and the absence of the patient's conscious reactions to them, in a (translated) passage that is reproduced in the notes.[420] Nor are these observations about the psychic effects of

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[420] Concerning neuroleptics' propensity to induce psychic indifference in patients, ***even indifference to pain***, J. Sigwald and D. Bouttier ("Le chlorhydrate de chloro-3(dimethylamino-3-propyl)-10-phenothiazine en pratique neuro-psychiatrique courante" *Ann. Med. 54*, 1953, pp. 150-51; translated by Swazey [1974, p. 114]) write a passage that prefigures Dennett's (1978) discussion in "Why You Can't Make a Computer That Feels Pain":

"From experimental work, it is known that chlorpromazine has the property of potentiating analgesics; but administered by itself, it has its own analgesic action in man. Thus, having administered it to patients suffering sharp pain, we confirmed its soothing action; but we occasionally thought that it had an effect different from that of other analgesics, producing an indifference to the pain, rather than an analgesia. In one case, for example, the patient felt sharp pain due to herpes zoster, which nothing relieved and for which we recommended chlorpromazine; seeing her several days later in consultation, we were surprised to find a euphoric woman, who said she was content with her condition; trying to learn if the pains were diminished in intensity, in frequency, or in duration, we asked several questions, and she responded that she had experienced the same pain, that she had the same kind of attack, in duration and intensity, but that "it wasn't too bad" and that she was very satisfied with the treatment."

It should be noted that these investigators also found that the drugs produce a dissociation in psychotics' patients' response to hallucinations, rather than a reduction in the actual symptoms: e.g., after administering them to one woman with delusions of persecution who heard voices and was threatening to avenge herself on the person she suspected of being behind them, she no longer complained about the voices or made threats of vengeance, but they note that the hallucinations did not disappear: "When questioned, she says she hears voices as before, but she does not interpret them to herself...[although she] refuses to believe in [their] hallucinatory character" (p. 170 of Sigwald and Boutier, p. 115 of Swazey 1974). This is confirmed by the early investigators in other countries. First, an early British report by J. Elkes and C. Elkes of the University of Birmingham ("Effects of Chlorpromazine on the Behavior of Chronically Overactive Psychotic Patients," *British Medical Journal*, Sept. 4, 1954, vol. 2, 560-65), notes,

"The [improved] patients became quieter, less tense, and less disturbed by their hallucinations and delusions during the weeks they were receiving chlorpromazine; their eating, sleep, and social habits changed for the better....

...[However], [i]t is important to stress that in no case was the content of the psychosis changed. The schizophrenic and paraphrenic patients continued to be subject to delusions and hallucinations, though they appeared to be less disturbed by them.

.... The essentially symptomatic nature of the response has already been stressed and cannot be overemphasized. Although affect became more subdued, and attitude and behavior reflected this improvement, the ingrained psychotic thought disorder seemed to be unchanged." (from pp. 561-64 of orig., quoted in Swazey 150-52)

Likewise, the first North American publication on CPZ in psychiatry was written by Montreal's Heinz Lehmann and T.E. Hanrahan ("Chlorpromazine, New Inhibiting Agent for Psychomotor Excitement and Manic States," *AMA Archives of Neurology and Psychiatry*, Feb. 4, 1954, 71: 227-37), and they remark,

"Chlorpromazine has a pronounced inhibitory effect on certain functions of the central nervous system. Patients receiving the drug become lethargic. Manic patients often will not object to bedrest, and patients who present management problems become tractable. Assaultive and interfering behavior ceases almost entirely. The patients under treatment display a lack of spontaneous interest in their environment, yet are easily accessible and respond as a rule immediately and relevantly to questions even if awakened from sleep." (quoted in Swazey 1974, p. 154)

neuroleptics limited to the pioneering investigators; they are corroborated here by Fielding and Lal (1978, p. 91) in their "Behavioral Actions of Neuroleptics":

> The neuroleptic syndrome consists of suppression of spontaneous movements and operant behavior at a time when all spinal reflexes are normal. The subject shows a striking lack of initiative, becomes disinterested in the environment, displays few emotions, and a low level of affective behavior. Additionally, the patient is slow to respond to external stimuli and tends to display soporific effects and drowsiness. He is, however, easily aroused, capable of answering questions correctly, and possesses virtually intact intellectual functions. Symptoms of psychomotor agitation are markedly reduced. The patient becomes less excited, less agitated, less aggressive, and in control of his impulsive behavior.

The syndrome being described here, however – lethargic indifference and apathy – has a profile strikingly similar to that of lobotomies; small wonder these drugs have been called "chemical lobotomies" by many, including Walter Freeman himself, the man most responsible for popularizing lobotomies in America.[421]

That covers the first two expressions, then. However, in case you are wondering whether "the neuroleptic syndrome" really applies to the effects of antidepressants as well as to antipsychotics, it should be noted that in general the greatest difference between the two groups of drugs is that the latter affect dopamine levels more (and so produce more Parkinsonian and other extra-pyramidal symptoms or movement disorders),[422] but they definitely both have anticholinergic effects,[423] which are thought to be responsible for the sedation.[424] In fact, as Schoonover (1983, p. 53, my emphasis) notes, "Most psychoactive drugs have both peripheral and central anticholi-

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[421] Walter Freeman calls the effects of neuroleptics "chemical lobotomies" in his "Prefrontal Lobotomy: Final Report of 500 Freeman and Watts Patients Followed Up for 10 to 20 Years" (*Southern Medical Journal* 51, 1958, pp. 739-45), quoted in Valenstein (1986, p. 272). Breggin (1983) pursues the analogy in considerably more detail. Similarly, without adverse comment and seemingly oblivious themselves to the problem, Rosenblatt and Dodson (1981, pp. 26-27) report on the sorts of episodes that were caused by antihistamines that probably put Laborit onto his discovery of CPZ in the first place which highlight the frightening and troublesome character of this aspect of the neuroleptic syndrome: "In the late 1940s, so the story goes," they begin, a New York cab driver on antihistamines was pulled over: "You all right?" said the cop. "Sure," said the hack. For the life of him he couldn't figure out what he had done wrong. "Well, you just ran every red light for the last ten blocks," said the cop, "and either you're crazy as hell or you don't want to live too long."

...What really happened was medically noteworthy: The cab driver had *not* fallen asleep at the wheel. He had seen and recorded every traffic light, but he had disobeyed them because *their significance seemed irrelevant to him*! So the [pharmacological] revolution began in the late 1940s with an unwanted side effect from a popular drug...."

It scarcely needs mentioning that this sort of indifference not only compromises the patient's autonomy by interfering with his or her normal values and preferences (such as survival!), but it also puts their own and others' lives in jeopardy, as well.

[422] See, e.g., Korczyn (1980) on the relative specificity of anti-psychotics on the dopaminergic pathways and on the connection between dopamine-reuptake and extra-pyramidal symptoms such as "pseudo"-Parkinsonian tremors and shuffling gait.

[423] E.g., Davis (1985, pp. 1506-07) notes that "...most of the antipsychotic and antidepressant medications inhibit norepinephrine uptake, block [alpha]-receptors, and block cholinergic receptors, both centrally and peripherally, and can produce a family of autonomic side effects....In addition, almost all the antipsychotic compounds produce extrapyramidal side effects."

[424] E.g., Cole and Bodkin (1990, p. 22) state, "The relationship of side effects to differential actions of tricyclic antidepressants (TCAs) has been best presented by Richelson. He proposes that many common side effects are due to their anticholinergic effects. For example, sedation may be due to antihistaminic effects at the H1 receptor, and weight gain may be due to antihistaminic effects at the H2 receptor." See E. Richelson, "Antimuscarinic and Other Receptor-Blocking Properties of Antidepressants" (*Mayo Clinic Proceedings* 58: 40-46, 1983), and "Are Receptor Studies Useful for Clinical Practice?" (*Journal of Clinical Psychiatry* 44 [9, Sec 2]: 4-9, 1983).

nergic effects," and he explicitly makes the connection between antidepressants and the neuroleptic syndrome in 1977 when he issues the caution about drowsiness and psychomotor slowing.[425]

Considering that effects such as diminished consciousness and indifference are central characteristics of these types of drugs' clinical profile, then, we should be suspicious of the claim that they even help at all. That brings us back to the question, when the studies say they "work" as well as psychotherapy does, what kinds of improvements are being measured: a lift in depressives' mood and attitude about themselves and the world, or just an improvement in the vegetative symptoms? As a number of studies of the differential effects of pharmacotherapy and psychotherapy on depressive symptomology have revealed, it's the latter.

First, DiMascio *et al*. (1979) compared the symptomatic effects of sixteen weeks of the tricyclic amitriptyline with that of interpersonal psychotherapy and also a combination of both treatments on a total of 81 depressed subjects; as they comment, the combination of treatments worked best of all (a point I'll be returning to later on), while there were differential effects with the other two:

> Pharmacotherapy had its effects mainly on the vegetative symptoms, sleep disturbance, somatic complaints, and appetite. Improvement of sleep disturbance occurred quite early – within the first week – and was sustained throughout the 16 weeks. The effect of pharmacotherapy on mood and on interest occurred at 12 weeks. When individual symptoms were examined, the effects of psychotherapy were mainly on depressed mood, suicidal ideation, work and interests, and guilt, occurred slightly later, at four to eight weeks, and were sustained. (p. 1454)

Similarly, Rush and Beck *et al.* (1982) compared the differential effects of imipramine and cognitive therapy on 35 depressed subjects' self-concept and sense of hopelessness, and they found that the discrepancy between the subjects' view of themselves (as good looking/ugly, smart/dumb, etc.) and their goal for themselves was reduced more in the psychotherapy group, although "drug treatment may be better than cognitive therapy at reducing the discrepancy between patients' ratings of themselves and their ratings of how they think others see them in emotional areas," and that "the cognitive therapy group obtained significantly lower hopelessness scores than the imipramine group" (p. 864). Finally, Telner *et al.* (1988) started with 23 depressed inpatients, and after a wash-out period where they weeded out the ones who responded to placebo, they gave the others either imipramine, fluoxetine, or trazodone, and after three to four weeks, by which time approximately 50% of the sample had improved, they administered questionaires to test subjects along five dimensions which have been identified by cognitive therapists as central features of depressives' cognition (which they define on p. 279):

[425] In an earlier (1977) edition of Bassuk and Schoonover's (1983) and his (1983, p. 44), Schoonover writes: "Tricyclics may also cause psychomotor slowing and difficulty in concentration and planning. Although more attenuated than with the phenothiazines, some of these properties are similar to the neuroleptic syndrome. These effects should be explained to the patient if he is in a setting where active physical or mental performance is required. Weakness and fatigue, nervousness, headaches, agitation, vertigo, palsies, tremors, ataxia [poor coordination], paresthesias [numbness], dysarthria [spasticity of muscles], nystagmus ["Rhythmical oscillation of the eyeballs, either pendular or jerky"], and twitching are central symptoms that occasionally occur. Tricyclics also lower the seizure threshold in a manner similar to the phenothiazines. (quoted in Breggin [1983, pp. 166-67]; note that CPZ is a phenothiazine)"

1. Emotional Impact ("the felt aversiveness of negative situations and the pleasantness of positive situations").

2. Attribution of Causality ("the individual's tendency to attribute negative outcomes to the self and positive outcomes to external factors").

3. Generalization Across Time ("the individual's expectation that negative outcomes will extend into the future while positive outcomes will be short-lived").

4. Generalization Across Situations ("the individual's expectation that negative situations are typical of their lives while positive outcomes are atypical").

5. Perceived Uncontrollability ("the individual's belief that events (positive and negative) are beyond personal control").

When they compared the subjects who did not respond to the drugs to those whose clinical symptoms of depression were alleviated (as measured by the Hamilton [1967] scale, a standard means of evaluation), they found that the drugs "only altered cognitions in a limited way" (p. 281); in particular, Telner *et al.* (1988) found that there was only a significant difference between the responders and the non-responders on the fourth dimension, Generalization Across Situations. Thus, although patients on antidepressants may count as "improved" according to the items on the (1967) Hamilton scale such as insomnia, agitation, anxiety, loss of appetite, and weight loss, this doesn't mean that the "improved" subjects think things will get better in the future or that they deserve or are in control of whatever good things may happen to them. As Rush *et al.* (1982, p. 865, I've omitted their references) point out,

> The difference in effects of the two treatments on hopelessness may have important clinical implications. Hopelessness and suicidal intent are highly correlated....If cognitive therapy produces a greater reduction in hopelessness than does antidepressant drug treatment, an important reduction in suicidal intent may also ensue.

Antidepressants, then, help to regulate depressed peoples' digestive and sleep patterns better, and they reduce some subjects' anxiety about their future, not by making them more hopeful, but by making them more indifferent to their former worries. I'll be returning to these differential effects of psychotherapy and antidepressants in Section Four below, but now let's return to the adverse effects.

As I mentioned, the undesirable effects that were just reviewed, sedation and psychic indifference, are some of neuroleptics' *characteristic* effects, even at low doses, and we've also seen that these drugs can be very dangerous in extremely large doses. But, alas, we're not done yet, since it turns out there are still more side-effects to take into consideration, which accrue as the result of *long*-term use, even when more cautious amounts are administered. But before we do that and leave this section, I should round out my discussion of the neuroleptics in general by noting what can happen to patients who are hypersensitive to neuroleptics or who receive extra large doses over an extended period of time (something that happens all too frequently in state-sponsored institutions, as Breggin 1983, Szasz 1957, and Scull 1977 and others point out): they develop the n*euroleptic malignant syndrome*, or NMS. But because the NMS, although lethal a third of the time, has only been reported for up to 2.4% of the cases for antipsychotic medication (see Keck

et al. 1989, p. 914) and it is much more rare for the far less dopaminergic antidepressants, I'll relegate its discussion to the notes,[426] and proceed to the potential long-term neurological side-effects of antidepressants.

The Long-Term Neurological Side-Effects of Neuroleptics

As we'll see, both antidepressants and antipsychotics can produce certain neurological disorders if they are used for a long term, even at the so-called "therapeutic" doses. But why should we worry about the possibility of long-term effects? Don't patients just take the pills for a while, feel better, and then they're cured? According to the medical model, this is not likely, because mental illnesses such as depression and schizophrenia probably aren't the kinds of diseases that *can* be cured or eradicated, like viruses or infections can. Instead, they've been likened to diabetes, which involves a deep-seated problem in our biochemical architecture which can at best be *controlled*, not cured.[427] Of course, some neuropsychologists *do* postulate that these problems

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[426] Gelenberg (1983, p. 142) describes the neuroleptic malignant syndrome:

"This syndrome typically develops explosively over a 24- to 72-hr period beginning anywhere from hours to months after initial drug exposure....[it] has been associated with various antipsychotic drugs but is more prevalent with high-potency agents. Both sexes may be affected at any age, but among reported cases, young adult males predominate. Patients with organic brain disease appear to be at higher risk. Although the incidence of this disorder is unknown, it is probably not as rare as originally believed.

Management consists of discontinuing the antipsychotic drug immediately and instituting supportive measures. In most cases, the syndrome clears within 10 days (longer following long-lasting injections); in about 20% of cases, the patient dies. There is no known treatment at this time. The mechanism of this syndrome is believed to involve the basal ganglia and hypothalamus, but the exact pathophysiology remains a mystery."

Similarly, Keck *et al.* (1989, p. 915) operationally define NMS by the following three features:

"1. Hyperthermia. – Oral temperature of at least 38.0* C in the absence of another known cause.

2. Severe extrapyramidal effects characterized by two or more of the following – lead pipe muscle rigidity, pronounced cogwheeling, sialorrhea [excess salivation], oculogyric crisis [eyeballs rolling up into head], retrocollis [spasms in the back of the neck], opisthotonos ["A tetanic [drug-induced] spasm in which the spine and the extremities are bend with convexity forward, the body resting on the head and heels"], trismus [lockjaw], dysphagia [difficulty in swallowing], choreiform [involuntary, spastic] movements, festinating gait [a rapidly accelerating way of walking characteristic of people with Parkinson's disease], and flexor-extensor posturing.

3. Autonomic dysfunction characterized by two or more of the following – hypertension (at least a 20-mm rise in diastolic pressure above baseline), tachycardia (at least 30 beats per minute above baseline), tachypnea (at least 25 respirations per minute), prominent diaphoresis [perspiration], and incontinence."

The true horror of this condition is somewhat obscured by this clinical language, however. For a more gripping description of one unfortunate patient's malignant reaction to imipramine's parent drug the neuroleptic Thorazine – which has long been the mainstay of neuropsychiatric treatments – consult DiMascio, Shader, and David Greenblatt, "Extrapyramidal Effects," in Shader and DiMascio (1970), p. 103. As you'll see, this case actually falls just *short* of the full-blown neuroleptic malignant syndrome (according to Keck's criteria, at least), since there's no hyperthermia, but it's quite frightening, nonetheless:

"9 days after beginning thioridazine, he began to have bizarre facial grimacing with protusion of his lips in a duck-like fashion. He was also noted to be having frequent gagging with spitting up of only small amounts of clear sputum-like fluid. These "dry heaves" persisted for about 36 hours. He had a period of severe overbreathing with rigid posturing and it was felt that he was having difficulty swallowing and breathing and was perhaps obstructed in some way. Physical examination revealed no abnormality. However, he was quite anxious and had a tachycardia of 130 beats/minute. He was flushed. He had no elevation of his temperature during this 36-hour period. The next day he was found on the floor; his pulse was 120 beats/minute; his blood pressure was 180/180. When examined, he appeared to be holding his breath. His neck was bent back in a severe opisthotonic posture and his hands were in flexion with his wrists held rigidly and his fingers extended periodically and then clenched. There was an apparent tonic then clonic seizure-like pattern associated with this."

[427] See, e.g., Lehmann (1974, p. 164) or Davis (1985, p. 1485) for the analogy between mental illnesses and diabetes, which both require chemical maintenance treatments.

are due to viruses, but in either case it is well known that the relapse rate without sustained anti-depressant treatments is very high – perhaps about 65% within the first year[428] – and so, in order to prevent a relapse, pharmacotherapists usually prescribe so-called *maintenance* drug treatments extending long past the time when the main depressive symptoms have dispelled. Some physicians' handbooks (e.g. Law and Foltz 1990, pp. 180-181) call for at least another full year, and if nothing else is done to change the patients' attitudes or the circumstances in their lives, they may 'need' them indefinitely. Long-term effects, then, *are* relevant to the dispute.

The most well-known disorder that can result from taking neuroleptics for about six months or more is called "Tardive Dyskinesia" or "TD". Literally, TD is "a late-appearing difficulty in controlling movement," as Reber (1984, p. 759) points out, and its characteristics are: "involuntary, stereotyped and rhythmic movements of the upper body and the face, most commonly tongue protrusion, rolling movements, chewing, lip-smacking, abnormal finger movements, leg-jiggling and neck, trunk and pelvis movements." A fuller description is provided by Crane[429]; it's not a pretty picture. While TD is an ***iatrogenic***[430] or medically-induced

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[428] E.g., see Elkin *et al.* (1985, p. 312), citing GL Klerman, "Long-Term Treatment of Affective Disorders" (in MA Lipton, A DiMascio, KF Killam, eds., *Psychopharmacology: A Generation of Progress* New York: Raven Press, 1978), and KA Kessler, "Tricyclic Anti-Depressants: Mode of Action and Clinical Use" (in the same anthology):

"...research on relapse rates indicates that a substantial number of depressed patients experience a return of symptoms following initial remission. Klerman, reviewing these data, estimated that an average of 65% of depressed patients (combining inpatients and outpatients) have some degree of relapse within the first year, and Kessler also concluded that the mean untreated relapse rate approaches two thirds of all patients experiencing an acute depression. (These rates are somewhat lower for outpatients than for inpatients.)"

[429] Here George Crane, who has made it something of a personal crusade to point out the long-term neurological side-effects of neuropsychiatry's drugs, describes TD for us in detail (from Crane 1978 pp. 170-72):

"The tardive dyskinesias are by far the best known and the most common neurological disorders in patients treated with neuroleptics over a long period of time....TD in the oral region, also known as the buccal-lingual-masticatory syndrome, is the most frequent of all the disorders of motility. Although this syndrome complex is referred to as dyskinesia, it often includes abnormal posturing. In the more severe forms, deglutition [swallowing, respiration, and phonation are involved but, in the majority of cases, abnormalities of movement (and posture) are observed only in the tongue, lips, mandable, and cheeks. The tongue shows the greatest variety of motor abnormalities, a fact that can be readily explained by the great motility of this organ and the complexity of its muscular supply....Side-to-side sweeping, protrusion, quick darting in the midline (fly catcher's tongue), curling of the lip, and a combination of all these symptoms are the most typical lingual dyskinesias....Occasionally, rotating or ruminating masticatory movements of the lower jaw occur in the absence of lingual involvement. Similarly, rhythmical protrusion of the lips, smacking, or pouting may be the only manifestations. The sudden puffing of the cheeks with a noisy emission of air is very characteristic and occurs at the end of a series of oral activities.

...Abnormal activity in the upper extremities is somewhat less common than in the mouth. The fingers and wrists are more frequently involved than the elbow or shoulder. Movements may be irregular or slow and rhythmical, with a state of general relaxation being conducive to a greater regularity of movements. As in the oral region, both dyskinesias and dystonias can be observed in the upper extremities. Sometimes a series of flexions or extensions of the fingers is terminated by clasping of the fingers or by clawing. Torsion and flexion of the wrist may be the only signs or may be associated with intense dyskinesias of the fingers.

In the lower extremities, dyskinesia is manifested by alternating abduction and adduction of the thighs, flexions and extensions of the feet, and hyperextension of the big toes. Torsion of the ankles to an equinovarus posture may last a second or so. This abnormal motility plus the patient's tendency to shift the center of gravity backwards influence the gait in a characteristic fashion. The heel touched the ground before the rest of the foot, which gives the appearance of an overcautious and self-conscious gait. In the more severe cases, there is an inability to maintain the proper balance between the neck, waist, and pelvis, creating the impression of constant motion. In reality, these postural changes represent efforts to reestablish a normal equilibrium between segments of the axial musculature. At times, particularly after the sudden withdrawal of medication, patients feel that they are pulled to one side, and seek support by leaning on a wall or other solid object."

condition, it resembles some stages of naturally occurring conditions: the latter stages of some cases of epidemic encephalitis (a.k.a. encephalitis lethargica or sleeping sickness), and Huntington's chorea (or "St. Vitus's dance"). The many parallels between the effects of neuroleptics and encephalitis, including the appearance of long-term movement disorders, were noted by none other than Deniker himself;[431] while the analogy between TD and Huntington's, although not without problems, is supported by Korczyn (1980, p. 80), who notes that the latter can be a confounding factor in diagnosing the former, and Gelenberg (1983, pp. 132-33), who explicitly refers to choreas and jerky "dance" movements when describing TD.[432]

That's the condition, then; so how serious – and frequent – is the problem? Let's consider the former first. Many doctors regard the problem as relatively minor or mild: what's a little tongue wagging, they argue, if the drugs give you your life back? However, it is easy for neuro-psychiatrists to take this attitude to TD, because they mostly see it in patients who have been diagnosed as chronic schizophrenics, and they're used to them appearing crazy, anyway, while the patients themselves often refuse to even acknowledge that they've developed a disorder (on

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[430] "*Iatrogenesis*" is another important term which readers interested in disciplines such as neuroscience and medicine may not know about but should; it names the all too widespread phenomenon of illnesses produced by doctors in the course of their treatments: see Illich (1976, *passim*), or this passage by Tushnet (1971, p. 194):

"Starting with the arsphenamines and the later sulfonamides, medicine entered the modern age of wonder drugs. Antibiotics, psychotropics, blood derivatives, anticancer drugs – every year sees more and more novel additions to the inventory of weapons the doctor uses in his fights against disease. And every year sees more and more novel iatrogenic disorders brought on by those very weapons. (*Iatrogenic* comes from the Greek: *iatro'=physician* and *genos=cause*; hence, iatrogenic=caused by physicians. This is a new word, not found in dictionaries published prior to 1953. In 1954 Stedman's *Medical Dictionary* defined it as meaning "caused by a physician's injudicious statement," indicating that the disease was all in the patient's head. By 1961 the current broader meaning, "caused by physicians in the course of treatment" was well established.) Iatrogenic disorders have reached the point where a prominent physician [Dr. David M. Spain, *Complications of Medical Practice*, New York, 1963] sadly says, "Unfortunately iatrogenic disease can now take its place almost as an equal alongside the bacteria as an important factor in the pathogenesis of human illness."'"

[431] See Breggin (1983, pp. 78 ff.), which records this observation made by the aforementioned Pierre Deniker himself, in his retrospective 1970 "Introduction of Neuroleptic Chemotherapy into Psychiatry" (in *Discoveries in Biological Psychiatry*, F. Ayd, B. Blackwell, eds. Philadelphia: Lippincott, 1970): "It was found that neuroleptics could experimentally reproduce almost all the symptoms of lethargic encephalitis. In fact, it would be possible to cause true encephalitis epidemics with the new drugs. Symptoms progressed from reversible somnolence to all types of dyskinesia and hyperkinesia, and finally to parkinsonism. The symptoms *seemed* reversible on interruption of medication." (quoted in Breggin 1983, p. 79, with Breggin's emphasis) On the next page, both Breggin and Deniker note that such an epidemic *has* in fact happened, involving what seem to be ***permanent*** dyskinesias.

[432] Gelenberg (1983, pp. 132-33) writes,

"Tardive dyskinesia is characterized by involuntary, choreoathetotic movements involving the tongue, lips, jaw, extremities, and occasionally the trunk...it typically involves oro-bucco-lingual masticatory movements. These may include lipsmacking, chewing, puckering of the lips, protrusion of the tongue, and puffing of the cheeks. A common early sign is wormlike movements of the tongue. Other movements of the face can be observed, including grimacing, blinking, and frowning.

In the young, movements sometimes begin in the distal extremities and may consist of rapid, purposeless, quick, jerky movements distally – chorea ("dance") – or more sinuous, writhing movements proximally – athetosis. Occasionally, abnormal movements involve the trunk and pelvis."

Huntington's chorea itself is defined by *Stedman's* as "a chronic disorder characterized by choreic movements in the face and extremities, accompanied by a gradual loss of the mental faculties ending in dementia." Some of the disanalogies between TD and Huntington's are that TD involves dyskinesias other than choreas (i.e., "Irregular, spasmodic, involuntary movements of the limbs or facial muscles": *Stedman's*), and that "In general, patients with Huntington's disease have more trouble keeping their tongues out of their mouths, whereas tardive dyskinesia patients may have trouble keeping their tongues <u>in</u> their mouths" (Gelenberg 1983, p. 138 n., my emphasis).

the phenomena of "iatrogenic denial," see Breggin 1983, 159-61). But as Gelenberg (1983, p. 133) observes, the situation changes with less disturbed patients, and it can be quite distressing:

> The signs of tardive dyskinesia can range in intensity from minimal to severe. Patients' awareness of the movements similarly varies. Institutionalized chronic schizophrenic patients may deny even very severe movements, whereas a highly functioning patient with a mood disorder could be extremely troubled by the most minimal symptom. The movements may embarrass the patient and interfere with important activities such as eating, talking, and dressing. In rare instances, tardive dyskinesia can impair breathing and swallowing.

Similarly, Yassa (1989, pp. 65-66) studied the problem of impairment in 22 subjects with TD, and reports that some have an impaired gait (either "broad-based" or spastic) and posture caused by pelvic gyration or restless movements of the legs, such that they have difficulty in standing and in moving from one place to another, causing some to fall frequently (one sustained a fracture of the radius as a result); while others have severe speech difficulties caused by muscle spasms; another has to be spoon-fed; another's mouth is or was stuck open, causing constant neck- and head-aches; one patient "frequently thought of suicide because her TD movements embarrassed her"; and one woman's "speech was completely unintelligible and who also had severe TD in almost every area of her body." Moreover, as Breggin (1983, p. 90) points out, not only can these sorts of iatrogenic effects be quite a source of distress to the patients who have lost control of their bodily movements, but since they also make them *look* crazy, people tend to shun them, thus impairing their happiness and self-esteem further; on that theme, Yassa (1989, pp. 65-66) reports,

> Twelve patients complained of embarrassment caused by their movement disorder. They felt that people were looking at them on the bus, in the streets or in public places. None had clinical evidence of paranoid delusions, however. Two patients discontinued university courses and were forced to seclude themselves in their own apartments because they felt neighbours ridiculed them. Some family members reacted negatively to these movements and even fellow patients excluded several patients because they were grinding their teeth.

The most important thing about this scourge unleashed by neuropsychiatric drugs is that, by all indications, TD can persist indefinitely even after withdrawing from the drugs and is ***irreversible*** in at least half the cases (see Jeste *et al.* 1988, p. 39S).[433] The reason is that it probably results from neurological damage to the dopaminergic neurons in the basal ganglia, which control movement;[434] consequently, TD is not only not helped by the anti-parkinsonian medications

[433] E.g., see Crane (1978, p. 168) or Korczyn (1980, p. 80) or many other studies which report that a significant number of cases of TD are apparently irreversible; but note that Ananth (1979, pp. 28-29) cites his own observations and studies, and questions the "irreversible" classification, since some of his cases seemed to show improvement; he suggests we call it "treatment-resistant," instead.

[434] E.g., Gelenberg (1983, p. 134) reports, "The most widely held hypothesis about the mechanism of tardive dyskinesia involves the nigrostriatal dopamine pathway. Chronic blockade of dopamine receptors within the basal ganglia leads first to receptor underactivity, then to overactivity." Similarly, Seeman (1988, p. 4S) notes, "TD is most simply explained by dopaminergic supersensitivity resulting from nigral cell damage by long-term neuroleptics with various degress of ensuing denervation supersensitivity in the striatal regions controlling oral and other motions." However, the simplest explanation, that it's simply due to rebound hyper-sensitivity and hyper-activity of the dopamine receptors in the basal ganglia (the gray matter at the base of the cerebral hemisphere) doesn't account for the fact that it's often irreversible or treatment-resistant after the cessation of the drugs, so there's probably another explanation, at least for some cases, having to do with the fact that neuroleptics tend to bind to all types of melanin (which probably accounts for their inducing photosensitivity [e.g., see Shader and DiMascio 1970, 77 ff., *82*, which increases the risks of not only sunburn, but also of skin cancer, an increasingly serious problem as the ozone layer gets depleted and more radiation comes in), plus the fact that there's a lot of neuromelanin in the neurones in the substantia nigra, so the neuroleptics

which are usually prescribed to control movement disorders, but it's actually exacerbated by their anticholinergic effects[435] (which, as you recall, the antidepressants also have). Other treatments have been tried, such as tetrabenazine, but it can itself deplete central catecholamine stores and induce parkinsonism (see Korczyn 1980, pp. 80-81), which is why Jeste *et al.* (1988, pp. 39S, 42S) conclude,

> The main conclusion from previous reviews – that there is no satisfactory treatment for TD – remains equally valid today....in virtually every category of treatment in which sufficient data exist in both the earlier reviews and the present review, the treatments have been found to be less effective in the 1980s (except catecholaminergic drugs and anticholinergic drugs, in which there is a minimal difference). It appears that, not only is TD as refractory to treatment as it ever was, but those treatments that appeared promising at the end of the last decade appear less promising now.

Unfortunately, however, the symptoms of TD can be suppressed or masked by *increasing* the dosage of the offending neuroleptics (e.g., see Davis 1985, pp. 1508-9), but that just worsens the underlying condition in the long run (such that when and if the dosage is lowered or discontinued, the unwanted movements will surface worse than ever), so the best treatment for TD is to discontinue the drugs altogether (Gelenberg 1983, p. 139).

TD can be quite distressing, then, and it doesn't respond to treatment in at least half the cases, so it's quite a serious problem; but how common is it? The incidence rate is quite high for antipsychotics: officially about 20% of patients on neuroleptics in general for over three months develop the disorder (see the *L.A. Times* Dec 23, 1989; Gelenberg 1983, p. 134; or Davis 1985, p. 1509), but the rate is much higher for elderly patients, at least 50% (Crane 1973, p. 127; Crane 1978, p. 171), and perhaps as high as 75% for those over 70 (Breggin 1983, p. 92). As for its prevalence, working from the 1980 census figures, Morgenstern *et al.* (1987, p. 717) give the conservative estimate that "Among adult United States residents in 1980...there were approximately 193,000 neuroleptic-induced TD cases of which about 60 per cent occurred in outpatients," based on an estimated 1.2 million patients chronically exposed to neuroleptics, while Breggin (1983, p. 108) makes the far less conservative estimate of 1 to 2 million Americans in total, on the basis that between 5 and 10 million patients and prisoners receive major tranqui-

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probably build up there and cause damage, as Seeman (1988, pp. 3S-4S; I have omitted his references)) explains here:

"Because neuroleptics are highly surface-active and readily accumulate in cell membranes, they expand and invaginate cell membranes. This action may be seen not only in simple erythrocytes, but also in corneal cells, where the invagination ultimately leads to a myelin-like figure composed of a neuroleptic-membrane complex. Such myelin-like figures are also seen in the caudate nucleus in postmortem tissue from patients who had received long-term neuroleptics.

Thus, it appears that prolonged administration of neuroleptics may result in the accumulation of neuroleptics within two types of cell organelles – neuromyelin granules (or deposits) and neuroleptic-myelin figures...

The long-term accumulation of neuroleptics may result in local concentrations high enough to damage cell membranes with the possible ensuing death of the entire nigral cell. It is known that such neuroleptic-induced nigral cell damage occurs in rat striata, as well as in postmortem human tissues from patients who had tardive dyskinesia (TD). Reduced size of the basal ganglia has also been measured in tardive dyskinetic patients. This type of cellular pathology may also occur in the skin. The skin, however, has regenerative abilities that nigral cells do not.

Although non-neuroleptics such as imipramine also bind to neuromelanin, the membrane-binding and membrane-lytic properties of imipramine are much weaker than those of neuroleptics."

[435] See Shader and DiMascio (1970, p. 96), Gelenberg (1983, p. 134), or Ananth (1979, p. 24), the last of whom writes, "anticholinergic drugs are reported to either cause or provoke TD", citing LG Kiloh, JS Smith, and SE Williams, "Antiparkinsonian Drugs as Causal Agents in Tardive Dyskinesia," *Med. J. Aust.*, ii: 591-593 (1973).

lizers each year,[436] so it seems safe to say that we're talking about at least hundreds of thousands of people. Of course, it's not nearly so much of a problem with the antidepressants (which have far less influence on dopamine receptors): Griffith (1989, p. 996) classifies it as a "rare" adverse effect of tricyclics (without actually naming it "TD," since he's writing for a lay audience); and according to Yassa *et al.* (1987a, p. 244) there's only 24 reported cases of TD from antidepressants.[437] However, this low rate may be due to the shortage of studies of the long-term use of anti-depressants, because in their own study, Yassa *et al.* (1987a, p. 244) found that "TD developed in 6.0% of 50 psychogeriatric patients receiving antidepressant therapy," and they explain the probable mechanism.[438] Moreover, we're probably only beginning to gauge the true incidence of the long-term effects of neuropsychology's drugs in general, since they haven't been in use for very long. Imipramine itself was only brought to market in 1958 (Swazey 1974, p. 158), and some adverse effects may take ten or twenty years to develop. Given what's already known about TD, by all indications we should thus be extremely cautious about the long-term use of psychoactive drugs. This necessitates the availability of non-medical alternatives, because if neuroeliminativism were to out, patients would have no alternative but to remain on maintenance drugs in perpetuity and run the risk of TD or related problems.

Summary and Review: The Hazards of Antidepressants

All tolled, then, anti-depressants have a substantial number of problems: they commonly produce a variety of uncomfortable and distressing autonomic symptoms, they can be fatal, they can induce permanent neurological disorders, and on top of it all, they can backfire and produce psychological abnormalities such as schizophrenia-like symptoms.[439] So now you know what the actual unpleasant and dangerous effects of anti-depressants are, but it is even more important to appreciate that these so-called "side"-effects aren't random or freak occurrences – many are "proper accidents," as Thomists would say, or inevitable consequences of the central neurochemical mechanisms of these decidedly non-specific types of drugs.

As we have seen, antidepressants don't have isolated effects that just target our depressed thoughts or feelings – they ramify throughout our bodies. The drugs themselves get in the

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[436] On this question, Breggin (1983, p. 11) writes, "It is surprising that no reliable estimates exist concerning the numbers of individuals in the United States or elsewhere who are currently receiving treatment with the major tranquilizers. Mitchell Balter, chief of the Special Studies Section, Psychopharmacology Research Branch, National Institute of Mental Health, attempted to give a rough estimate in 1977 in response to a Congressional inquiry. Using the treatment year 1974 to 1975, he estimated that 5 million people had been treated with these drugs in office-based practices, and an additional 350,000 in hospitals, clinics, and community mental health centers, for a total of nearly 5.4 million persons. His estimate did not include prisons, boarding houses, nursing homes, and institutions for the retarded, which might have doubled the number to 10 million."

[437] Including imipramine: see J.J. Deckret, I. Maany, T.A. Ramsey, and J. Mendels, "A Case of Oral Dyskinesia Associated with Imipramine Treatment," *American Journal of Psychiatry* 134, 1977: 1297-98.

[438] See Yassa *et al.* (1987a, p. 244, their references have been omitted): "...antidepressants reported to cause TD (with the exception of tranylcypromine) have potent anticholinergic activity, leading to a decrease in acetylcholine and a relative increase of dopamine activity, thus precipitating or aggravating preeexisting TD. Also, antidepressants have a noradrenergic activity that may lead to the development of TD. Noradrenergic hyperactivity, rather than postsynaptic dopamine receptor supersensitivity, has been proposed as the underlying mechanism in TD."

[439] The parallel between the adverse effects of antidepressants and schizophrenic-like symptoms was drawn by Davies *et al.* 1971 (op. cit.); see Breggin (1983, p. 173).

bloodstream (they can even fatally alter the composition of the blood by inducing aganulocytosis, as we saw) and they spread throughout the body,[440] concentrating mainly in the heart and the brain, and imposing a severe burden on the liver all the while. Even within the brain, their effects are far from specific. As we have heard, imipramine prevents the excitatory neurotransmitters serotonin and noradrenaline from being absorbed back into neurons, but as the anatomist O. T. Phillipson notes, "The noradrenaline and serotonin neurones innervate a ***vast*** area of tissue throughout the brain and spinal cord" (in Gregory 1987, p. 200, my emphasis). But their effects don't stop there, since as Edelstein (1980, p. 23) records, tricyclics not only block the re-uptake of noradrenaline and serotonin, but they also block alpha-adrenoreceptors and affect acetylcholine and histamine. Interfering with these systems results in a variety of uncomfortable, antitherapeutic, and hazardous side-effects, as we have seen. The moral to be drawn from these considerations is that antidepressants' therapeutic effects and side-effects are probably irrevocably linked, and that we can't interfere with neurotransmitter balances with impunity.

However, since my case against neuropsychology has been premised so far upon the failings of tricyclics alone, I should now say something about the other kinds of antidepressants. Until very recently, the only major alternative to tricyclics were the MAOI's or Mono-Amine Oxidase Inhibitors. They're certainly no better, since they also affect the concentration of the stress hormone noradrenaline in the synapses (by blocking the action of monamine oxidase, the chemical which inactivates norepinephrine – see, e.g., Restak 1979, p. 170), and so produce many of the same autonomic and sedative side effects that tricyclics do,[441] and they impose considerably more dangers and inconveniences, as well, because they can have disastrous and even life-threatening effects on peoples' blood pressure if they ingest certain common foods.[442]

MAOI's may soon be a thing of the past, however, in this country, at least (although perhaps not in others, due to the pharmaceutical companies' deplorable practice of unloading unsafe drugs on Third World countries[443]), thanks to the recent development of a more refined antidepressant that

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[440] As Law and Foltz (1990, p. 180) comment, "The extreme fat solubility of these drugs accounts for their wide distribution throughout the body."

[441] For the adverse effects of MAOI's, see, e.g., Schoonover (1983, pp. 60 ff.); or Edelstein (1980, pp. 35 ff.).

[442] MAOI's can precipitate hypertensive crises; as Ebert and Shader (1970, p. 153) explain, "Clinically, the attacks are characterized by sudden throbbing headache, flushing, hyperpyrexia ["Extremely high fever."], and high systolic and diastolic blood pressures. In rare instances, cerebrovascular accidents, heart failure, and death have occurred." Schoonover (1983, p. 59) adds that photophobia, nausea, vomiting, palpitations, arrhythmias, and pulmonary edema (an accumulation of fluid in the pulmonary artery leading from the heart's main right ventricle) are symptoms of hypertensive attacks, as well. These are usually triggered by tyramine, a protein in yeast extracts and cheese. Consequently, foods such as cheese and bread products, alcoholic beverages, cream, coffee, chocolate, figs, raisins, soy sauce, MSG, egg plant, avocados, pickled herring, liver, and broad beans have to be avoided (see Schoonover (1983, p. 61), or Edelstein (1980, 35 ff.), which can cut into someone's diet considerably. In addition, certain other medications, including cold remedies, also have to be avoided.

[443] See Mintz (1965), Silverman and Lee (1974), Pekkanen (1973), or my (forthcoming) concerning these and other unethical practices of the so-called "ethical" drug companies; e.g., Pekkanen (1973, p. 80) writes,

> "Ritalin, the amphetamine-type drug produced by CIBA, ran a series of ads for "Environmental Depression." One of these depicted a housewife with stacks of dishes to wash, and wearing an exhausted expression; the ad suggested Ritalin to provide the quick jolt to get her through the day ..."Ritalin Sparks Energy Quicker by a Long Shot," said another ad, with a picture of a cannon superimposed on the text. Never mind that thirty years before the AMA had specifically warned against the use of amphetamines for energy lifts. Children were not spared from mood drug promotion either. Pfizer Laboratories promoted the tranquilizer Vistaril by showing the tear-streaked face of a young girl and suggesting its use for children who are frightened by "school, the dark, separation, dental visits, 'monsters.'"

selectively affects serotonin reuptake, thus sparing patients the effects of excesses of noradrenaline. In particular, weight gain is not a problem with this new generation of drugs, and neither is sedation. In fact, they act as mild stimulants, which is to be expected, after all, since that was their rationale in the first place. Since these drugs have already caught on in a big way and received considerable publicity (see the cover story by Cowley *et al.*, 1990), we should take a little time to review their effects and limitations, as well, concentrating on their main exemplar, fluoxetine or Prozac.

According to the respected non-profit *Medical Letter* (Vol. 30, Issue 764, April 22, 1988, pp. 45-48), fluoxetine appears to be as effective as tricyclics, and it produces fewer incidences of anticholinergic side effects (such as dry mouth, constipation, or urinary retention), orthostatic hypotension, and cardiac conduction disturbances. Adverse effects such as headaches, nausea, nervousness, and insomnia, however, occur *more* frequently; according to its own manufacturer's (Eli Lilly) advertisements, "Anxiety, nervousness, and insomnia were reported by 10% to 15% of patients treated with Prozac," while nausea occurred in 21% of the cases. But the biggest difference seems to be that Prozac doesn't cause the weight gain that is often associated with tricyclics, and it may actually cause weight loss (averaging 10 pounds – see Boyer and Feighner, 1990, p. 137). Although this has brought a rush of people into their doctors' offices to get the drug (such that Prozac now outsells the other antidepressants, at least in retail sales[444]), like the amphetamines which were used before it to help stimulate people and curb their weight,[445] fluoxetine is dangerous in high doses or when used in combination with other drugs, and it has a number of other problems. First, as the *Medical Letter* (*op. cit*., p. 46) notes, "Like tricyclics, fluoxetine may precipitate mania or hypomania" (a point I'll be returning to below; they cite B Lebegue, *Am J Psychiatry*, 144: 1620, Dec 1987), and they add it "may rarely precipitate seizures in patients with convulsive disorders" (12 cases in 6,000 trials, according to Eli Lilly), and "Fluoxetine overdosage has been associated with agitation, vomiting, and seizures; two deaths have occurred after ingestion of multiple drugs including fluoxetine." As the last point indicates, a related drawback of Prozac is that it lingers in the body for a long time, so if patients have to stop taking it because of its adverse effects – and according to its own manufacturer, fifteen percent of the 4,000 patients in the premarketing clinical trials *did* discontinue treatment because of adverse effects – then they have to go at least five weeks without medical treatment, because of the risk of dangerous and even deadly interactions with other antidepressants or medications.[446] Some withdraw from the drug because of the symptoms already mentioned, such as nausea and anxiety, while others are hypersensitive to it and develop rashes and a flu-like reaction (which can also afflict users of tricyclics).[447] Another problem with Prozac is that, like

[444] Monroe (1990) reports that the premiere drug in this group, Fluoxetine or Prozac, generated $280 million in sales in 1989, about as much as all the other antidepressants combined, making it "the undisputed market king," even though at $1.50 per pill it is about ten times as costly.

[445] Concerning the rampant use of amphetamines in the nineteen-fifties and 'sixties as diet- and "pep"-pills, see, e.g., Silverman and Lee (1974), or Pekkanen (1973), or Mintz (1965).

[446] Monroe (1990, p. E-1) that there have been at least three American deaths from Prozac cross-reactions with other drugs.

[447] The fact that about 4% of Prozac users develop rashes and flu-like reactions is reported in Prozac's own package insert, the *Medical Letter*, and Boyer and Feighner (1989, p. 138), who add that one-third of the cases are severe enough to require drug discontinuation and, in some cases, symptomatic treatment. Hypersensitivity reactions to tricyclics are reported in Edelstein (1980, p. 23): "Allergic reactions to these compounds include rash, urticaria [hives or welts], and cutaneous vasculitis [inflammation of the skin's blood vessels];" and as I mentioned in note 56 above, photosensitivity is also a problem with tricyclics: see, e.g., Shader and DiMascio (1970, pp. 77 ff.).

the tricyclics and other psychotropic drugs, it can induce sexual dysfunctions, such as delayed orgasms in men (over an hour, in some cases), and anorgasmia in women.[448] An additional problem that is starting to emerge is that, despite its claims to specificity, fluoxetine can apparently induce or exacerbate extra-pyramidal symptoms such as Parkinsonian rigidity and shuffling gait, just as the neuroleptics do.[449] And most importantly, as was mentioned, like the amphetamines themselves, Prozac can induce mania and suicidal behavior.[450] Despite its improvement on some dimensions, then, Prozac is far from a perfect or a wonder drug.

Clearly, then, antidepressants have major drawbacks and limitations. If some form of "folk" psychology can work as well as they do without producing equivalently serious side-effects, then I submit that we not only *should* employ the former instead of the latter (contrary to any *pre-scription* neuroeliminativists might be making), but very probably we always *will* keep it in use (contrary to their premature *prediction*), *however* suspect its theories might be. We've already seen that such an alternative is available, since *cognitive* therapy is nearly as effective as imipramine; but I submit further that if we examine applied intentional psychology closer, we'll see that it not only works, but its theories are also quite sensible and very likely true, as well. Accordingly, let's turn to the cognitive approach now.

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[448] See Herman *et al*. (1990), who report on a number of cases who were either unable to achieve orgasm or who took an inordinately long time while on the drug, but the problem cleared up when the drug was discontinued; as Cole and Bodkin (1990, pp. 23, 25) report, impotence is more often the problem with men on tricyclics, although with some drugs such as Trazodone, *priapism* or permanent erections can occur, which may require major surgery if not treated within 24 hours, or else permanent impotence can occur; the AMA Family Medical Guide (1987, p. 591) explains, "If the priapism lasts for three or four hours, the spongy tissues of the penis may be permanently damaged, which can make erection impossible."

[449] A letter by J L Tate ("Extrapyramidal Symptoms in a Patient Taking Haloperidol and Fluoxetine") in the *American Journal of Psychiatry* (1989, 146: 399-400) first drew attention to the problem, and since then there have been several other reports linking Prozac and Parkinsonian symptoms, including two letters in the same journal later that year (1989, 146: 1352-53) by RH Bouchard, E Pourcher, and P Vincent; and TM Brod, respectively. Based on their two cases, Bouchard *et al*. (p. 1353) hyothesize that "...fluoxetine has an indirect dopamine-blocking effect, at least in some persons at risk. An explanation could be that the increased serotonergic activity of the raphe nuclei projections on nigral cells may have deleterious effects on dopamine turnover in persons with poor nigrostriatal dopamine reserves."

That hypothesis was tested on rats by Ross Baldesserani an Elda Marsh, who give a preliminary report of their findings (which are to appear in *Biochemical Pharmacology*) in a letter in the *Archives of General Psychiatry* (47, 1990, 191-92):

"The results indicate that a relatively large dose of fluoxetine moderately but significantly inhibited the synthesis of catecholamines acutely in several dopamine-rich areas of the mammalian forebrain and that, while this short-term effect may diminish with treatment elsewhere, it appeared to persist or even to increase in the hippocampus and the extra-pyramidal region (striatum). The findings support the hypothesis of Bouchard *et al*. and are consistent with other evidence that serotonin may exert a significant inhibitory action on dopamine neurons of the midbrain and brain stem projecting to forebrain."

[450] E.g., in the *Journal of Nervous and Mental Disease* Mandalos and Szarek (1990, p. 57) report on a "Dose-Related Paranoid Reaction Associated With Fluoxetine," and cite a few other published cases, and conclude that, "like other antidepressants, fluoxetine is capable of triggering psychotic symptoms in some individuals;" and in the *Journal of Clinical Psychiatry*, Cole and Bodkin (1990, p. 25) report, "We have seen several patients who developed new suicidal urges and agitation and impulsivity after a few weeks of fluoxetine therapy. The effects seem to be due to the drug since the suicidal dysphoric state abates when the drug is stopped." Likewise, Teicher, Glod, and Cole report in the *American Journal of Psychiatry* (1990: 147, p. 207): "Six depressed patients free of recent serious suicidal ideation developed intense, violent suicidal preoccupation after 2-7 weeks of fluoxetine treatment. this state persisted for as little as 3 days to as long as 3 months after discontinuation of fluoxetine. None of these patients had ever experienced a similar state during treatment with any other psychotropic drug.'"

The Defendant: Psychotherapy

Now that we've seen what lies behind "Door Number One" – where depressed people are treated by neuropsychologists as diseased patients and subjected to a variety of unpleasant and even fatal side-effects – let's see what's behind the door that leads to them being treated as clients with psychological problems, the door eliminativists think should be slammed shut for good in scientific contexts, because it just leads to a lot of talk. In this Section, I want to correct the misconception that psychotherapy is *just* a lot of (useless) talk, by describing Aaron Beck's cognitive/behavioral approach (ignore the oxymoron for now), a more contemporary and stream-lined version of 'on-the-hoof' (PSC) intentional clinical psychology than philosophers familiar with the beleaguered psychoanalysis may know about. This approach, whose efficacy is now well established, as we saw in Section Two, involves both the Cognitive ***Theory*** of Depression, and the Cognitive ***Therapy*** which flows from that understanding. Let's start with the theory behind the therapy.

The Cognitive Theory of Depression

As its name suggests, Beck's cognitive approach to depression focusses upon the cognitions underlying our misery or maladaptive behavior – not to neglect emotions, as we shall see, but to explain why they take the shape they do. In his view, depressed people selectively shape their interpretations of the world and their on-going experiences with systematically distorting patterns of thinking that are centered around their views about themselves and what they feel they deserve to get out of life. As we'll see, this approach fits squarely within the notional world framework I have been defending.

Like so many therapists, Beck was trained in psychoanalysis, but he gradually became disenchanted with 'deep' interpretations about hidden unconscious motivations. When he started paying more attention to the sometimes all too evident maladaptive cognition that ***is*** (if just barely) accessible to consciousness (see, e.g., Beck 1976, pp. 34, 318), he soon learned how to train patients to clarify their thoughts and analyze their self-destructive and maladaptive reasoning. Beck also both pared down the psychodynamic model considerably in some areas (cutting out the "Id" altogether, it might seem) and shored it up in others (particularly the Ego and the Super-Ego), by integrating models from cognitive science to give them some more concrete structure, as we're about to see.

But before we do, I'll begin by following the suggestions of Brown and Harris in their *Social Origins of Depression* (1978) to supplement the more narrow cognitive account with certain psychosocial hypotheses about the events which frequently precipitate serious bouts of depression, in order to explain how the maladaptive cognition that's being identified often arises as an understandable response to crushing life experiences, rather than simply appearing from nowhere, or resulting from isolated endogenous biochemical abnormalities.

The Psychosocial Etiology of Depression

According to the psychosocial model, depression can be precipitated by a variety of social factors and life-events which have nothing to do with people's abnormal brain chemistry *per se*. For example, as we all know, ***bereavements*** can trigger serious bouts of depression, but as Brown and Harris (1978, p. 286) found in their study of 458 women in Camberwell, England,[451] actual *deaths* of loved ones were only involved in about ten percent of the cases, while the majority of cases involved the loss of someone's love or of a treasured identity or role. In each case, however, the unifying feature of triggering events is that the subjects who became depressed perceived them as "long-term threats":

> Reading through the descriptions of events leaves us in no doubt that loss and disappointment are the central features of most events bringing about clinical depression. ...Long-term and not short-term threat is important because it correlates closely with the experience of loss if this is seen to include: (i) separation or threat of it, such as death of a parent, or a husband saying he is going to leave home; (ii) an unpleasant revelation about someone close that forces a major reassessment of the person and the relationship, such as ... finding about a husband's unfaithfulness; (iii) a life-threatening illness to someone close; (iv) a major material loss or disappointment or threat of this, such as a couple living in bad housing learning that their chances of being rehoused were minimal; (v) an enforced change of residence, or the threat of it; and finally (vi) a miscellaneous group of crises involving some element of loss, such as being made redundant in a job held for some time, or obtaining a legal separation. (pp. 103-104)

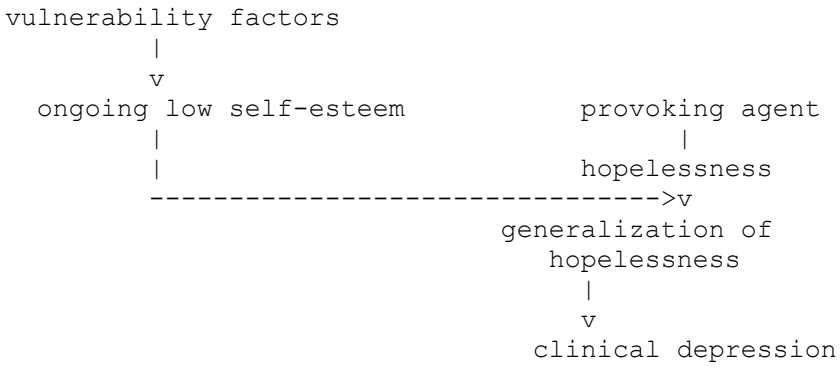
As they mention (on p. 103), it might be expected that these sorts of devastating events would be capable of provoking depression, but they add (on p. 128) that it's *only* events that are perceived as severe long-term threats that can do so, and they note, "They can act in this way for six months before onset – and perhaps occasionally for as long as one year." The common feature of these events, then, is that they involve a major loss or disappointment, but clearly there must be other factors involved, as well, since not everyone who suffers a major loss experiences major depression (only about one in five do, by their reckoning, p. 286) and since some people even rise to the occasion. The crucial matter isn't the loss *per se*, they argue, it's

> ...their effect on a woman's thoughts about her life that is critical...the experience of hopelessness (p. 116).
>
> ...what is important about such loss for the genesis of depression is that it leads to an inability to hold good thoughts about ourselves, our lives, and those close to us...[and to] the loss of faith in one's ability to attain an important and valued goal (p. 133).

We'll be hearing a good deal more about this syndrome of pessimistic thinking momentarily when we examine the "Cognitive Triad" described by the Cognitive Theory of Depression, but first it should be noted that not everyone is equally susceptible to such a reaction, in Brown and Harris's (1978, pp. 235-36) view, because there are certain vulnerability factors in the women they studied which account for the disparity: "loss of mother before eleven, presence at home of three or more children under fourteen, absence of a confiding relationship, particularly with a husband, and lack of a full- or part-time job." These factors are united, they submit, by the fact that they all compromise the subject's level of self-esteem and sense of mastery before the

[451] Camberwell is a district of London, England; Brown and Harris focussed on women because the prevalence of women depressives is much higher, and they wanted to reduce their interviewing costs by restricting it to one gender. Brown and Harris (1978, p. 22) note, "Women ususally form about two thirds of all depressed patients treated by psychiatrists," citing C. Silverman (*The Epidemiology of Depression*, Baltimore: The Johns Hopkins Press, 1968, p. 73) and J.K. Wing and A.M. Hailey (*Evaluating a Community Psychiatric Service*, London: Oxford University Press, 1972), and they add, "community surveys, at least in urban areas, have arrived at much the same conclusion."

serious event,[452] which impedes their ability to work through their disappointment or loss constructively, while "It is not difficult" to see how their opposites (growing up with both parents, having a full or part-time job, a close relationship with a spouse, and not having three or more children under fourteen at home) can protect people from feelings of utter hopelessness in the face of major loss.[453] The bottom line, they suggest, is that "the vulnerability factors play an important part because they limit a woman's ability to restore some sense of value" (p. 238), and without them a woman "might well be able to work through the experience of loss and disappointment and find new sources of positive value, thus keeping her experience of depression within the bounds of a 'borderline case' or most often of normal grief, simple sadness, or distress" (p. 286). For those who appreciate such things, they provide a diagram of this psychosocial model of depression (on pp. 237-38):



[452] Brown and Harris (1978, p. 235) write, "Why do relatively so few people develop such hopelessness? ...a person's ongoing self-esteem is crucial in determining whether generalized hopelessness develops – that is, response to loss and disappointment is mediated by a sense of one's own ability to control the world and thus to repair damage, a confidence that in the end alternative sources of value will become available. If self-esteem and feelings of mastery are low *before* a major loss and disappointment a woman is less likely to be able to imagine herself emerging from her privation."

[453] Brown and Harris (1978) explain how the reverse of the vulnerability factors can bolster people's self-esteem and protect the four-fifths of the people who *aren't* overcome by loss:

"In the case of employment, not only does the role identity of worker become available to a woman but her extra social contacts will often provide her with new interpersonal identities. The existence of an intimate relationship most probably acts by providing not only a role identity but also one that is likely to be appraised as successful, and thus a source of self-esteem. In a similar way it is probably usually easier to perform successfully in the role of mother when there are fewer than three children under fourteen, and it is easier for a woman to spend time outside the house building new role identities if she has fewer children who can be left with neighbours or relatives, or even accompany her more easily. (pp. 237-38)

...If a woman has three or more children under fourteen living at home or has no employment outside the home, she is less able to move into new areas of activity or to make new contacts on which she can build new sources of value. The role of isolation in depression is also suggested by the ability of an intimate relationship to reduce risk of disorder. While such a relationship is likely to help provide some women with a basic sense of self-worth it also has its more active aspect. The availability of a confidant, a person to whom one can reveal one's weaknesses without risk of rebuff and thus further loss of self-esteem, may act as a buttress against total evaporation of feelings of self-worth following a major loss or disappointment. Furthermore, the ability to talk with someone about one's feelings is a safe-guard against some sort of blanket defence mechanism of denial preventing the working through of grief. (pp. 286-87)"

(It might be noted that these factors explain why divorces are such double-whammies: they both provoke depression – since you experience a significant loss and are forced into a reappraisal of yourself or the other person or both – *and* they make you more vulnerable to it, since they deprive you of the intimate relationship in which to talk about these feelings which have been opened up.) And finally, losing one's mother while young is harmful, they argue, because she was the person who most supported the child and controlled the world for him or her, and when she died, so did the child's budding sense of mastery, leading to increased dependence and worsened self-esteem (p. 240).

We've now heard enough about some of the external events and situations that precipitate and predispose us to depression to get the gist of the ***social*** aspect of this psychosocial condition, so let's go on to concentrate on the psychological part, which occupies the bottom corner of the diagram: the feeling "that the self is worthless, the future hopeless, and the world meaningless" (p. 286).

The Cognitive Model of Depression

There are three main aspects to the cognitive model of depression, involving certain cognitive errors or lapses in reasoning; negative schemas; and "the cognitive triad." Let's go through these in reverse order.

As Beck and Rush (1978, pp. 201-203) explain,

> The cognitive triad consists of three major cognitive patterns that induce the patient to regard himself, his future, and his experiences in an idiosyncratic manner.
>
> The first component of the triad revolves around the patient's negative view of himself. He sees himself as defective, inadequate, or unworthy. He tends to attribute his unpleasant experiences to a physical, mental, or moral defect in himself. The patient believes he is undesirable and worthless *because* of his presumed defects. He tends to underestimate or criticize himself because of them. Finally, he believes he lacks the attributes he thinks are essential to attain happiness and contentment.
>
> The second component consists of the depressed person's tendency to interpret his ongoing experiences in a negative way. He sees the world as making exorbitant demands on him and/or presenting insuperable obstacles to reaching his life goals. He misinterprets his interactions with the world around him as evidence for defeat or deprivation, These negative misinterpretations are evident by observing that the patient negatively construes situations *even* when less negative, more plausible, alternative interpretations are available....
>
> The third component consists of a negative view of the future. As the depressed person looks ahead, he anticipates that his current difficulties or suffering will continue indefinitely. He expects unremitting hardship, frustration, and deprivation. When he thinks of undertaking a task, he expects to fail.

Understanding the cognitive triad can go a long way to accounting for some of the major symptoms of depression such as sadness and apathy, as Beck and Rush (1978, p. 203) go on explain, since these negative views about the self, the present, and the future may be responsible for the depressed mood; suicidal wishes, for example,

> ...can be understood as an extreme expression of the desire to escape from what *appears* to be insolvable problems or an unbearable situation. The depressed person may see himself as a worthless burden and consequently believe that everyone, himself included, will be better off when he is dead.

But to understand how the triad is implemented in our thinking, we need to turn to the *second* aspect of the cognitive model, which involves the negative schemas underlying these patterns of thinking.

Schemas are a kind of data structure that we use to organize and interpret experience, as Beck and Rush (1978, p. 203) explain:

> Any situation is composed of a plethora of stimuli. An individual selectively attends to specific stimuli, combines them in a pattern and conceptualizes the situation...a particular person tends to be

> consistent in his responses to similar types of events....The term "schema" designates these stable cognitive patterns.

The trouble with depressives is that they typically employ such negative or self-destructive perfectionistic schemas as, "Unless I do everything perfectly, I'm a failure!" (see Beck and Rush 1978, p. 203). Beck calls the discrete products of these schema "automatic" thoughts, because they usually operate rapidly at the threshold of awareness (e.g., see Beck 1976, pp. 29 ff.); in this case, the subject has the occurrent thought, "I'm a failure," every time he does anything the least bit wrong. With these sorts of hyper-critical and self-castigating schemas constantly filtering their experiences, it's not surprising that depressed subjects feel that they don't measure up, and they feel badly as a result.

Readers familiar with Freud will no doubt notice the similarities between the cognitive account at this point, and Freud's explanation of "melancholia" as anger turned inward by a super-ego that exacts even more punitive standards than the parents or authorities it modelled itself after had demanded previously.[454] This is as it should be, because Beck preserved what was right in Freud's model, while suspending the hypothesis that depressives have the instinctual *need* to hate or punish themselves (see the Preface to Beck *et al.* 1979).

The third feature of the cognitive model is its identification of such cognitive errors or distorted patterns of thinking as arbitrary inference, selective abstraction, overgeneralization, magnification, minimization, and personalization (or relating external events to one's self even when there's no basis for doing so).[455] This aspect of the theory will be familiar to anyone versed in logic, so I will consign most of them to the notes,[456] and have Rosenhan and Seligman (1984, p. 332) illustrate just one of them here: *Selective abstraction* , which

> ... consists of focusing on one insignificant detail while ignoring the more important features of a situation. In one case, an employer praised an employee at length about his secretarial work. Midway through the conversation, the boss suggested that she need not make extra carbon copies of her letters any more. The employee's selective abstraction was, "The boss is dissatisfied with my work." In spite of all the good things said, only this was remembered.

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[454] See Freud, "Mourning and Melancholia" (in **SE** 14: 237-58), about which Simon (1978, p. 236) notes, "When Freud formulated the theory presented in "Mourning and Melancholia," he first observed the patient's excessive self-reproaches and then posited a mental agency in charge of self-reproach (the superego). If the degree of self-recrimination is excessive and pathological, then the agency that regulates self-reproach and self-praise must be malfunctioning."

[455] On these and other patterns of maladaptive or distorted thinking, see, e.g., Beck and Rush (1978, p. 204), or Beck (1976, p. 89 ff.).

[456] Concerning the other sorts of "cognitive errors" that darken the experience of depressives, according to Beck's account, Rosenhan and Seligman (1984, p. 332) write:

"*Arbitrary inference* refers to drawing a conclusion when there is little or no evidence to support it. For example, an intern became discouraged when she received an announcement which said that in future all patients worked on by interns would be reexamined by residents. She thought, incorrectly, "The chief doesn't have any faith in my work." ... *Overgeneralization* refers to drawing global conclusions about worth, ability, or performance on the basis of a single fact. Consider a man who fails to fix a leaky faucet in his house. Most husbands would call a plumber and then forget it. But the depressive will overgeneralize and may go so far as to believe that he is a poor husband. *Magnification and minimization* are gross errors of evaluation, in which small bad events are magnified and large good events are minimized. The inability to find the right color shirt is considered a disaster, but a large raise and praise for his good work are considered trivial. And lastly, *personalization* refers to incorrectly taking responsibility for bad events in the world. A neighbour slips and falls on her own icy walk, but the depressed [person] blames himself unremittingly for not having alerted her to her icy walk."

In sum, according to the cognitive theory of depression, people stay depressed due to their negative ways of thinking about themselves, the world, and the future. That's a sketch of what cognitive therapists *think* is involved in depression, then; now let's see what they *do* about it. As you might expect, the therapeutic rationale that follows from this understanding of the condition is straightforward: depressed people need an "attitude adjustment" – the negative thinking must be overturned. According to cognitive therapy, a good way to achieve that end is to use *rational persuasion* to get people to adopt healthier or more positive ways of thinking and living, so let's examine the actual therapy itself.

Cognitive Therapy

Unlike the literally laid-back approach of psychoanalysts (with their couches and free-associations) and the relatively non-directive therapists who pattern themselves after Carl Rogers, the practitioners of the third major school of psychotherapy take a highly active and interactive approach. The two main forms within this "cognitive-behavioral" classification, "Cognitive" and "Rational-Emotive" Therapy (RET), were developed by the first-rate psychiatrists Aaron Beck and Albert Ellis, respectively, who both started as classical psychoanalysts. However, although practicing psychotherapists rank Ellis as vastly more influential, and his RET is simpler to learn (literally a matter of A-B-C's!), there isn't as much evidence available about its effectiveness as there is for Cognitive Therapy's, and I don't want to speculate on its future prospects without knowing how well it works now. The question, then, is what is Cognitive Therapy? First, I'll say a little about what it has in common with most kinds of psychotherapy in general, and then I'll describe its more specialized features in more detail.

As in most forms of psychotherapy, the goal of Cognitive Therapy is to uncover subjects' reasons for behaving and get them to know themselves better, in order to improve their lives. This involves encouraging clients to open up about themselves, interpreting and evaluating whatever communications are forthcoming in order to make sense of their condition, and then imparting that understanding to them. As we saw in Chapter Three, this requires clinical practitioners to adopt the *narrow* perspective; or as Beck (1976) explains in the note,[457] they have to use empathy to interpret the significance of the subjects' communications or the situations they're in

[457] As Beck (1976) explains,

> "To understand the emotional reactions to an event it is necessary to make a distinction between the dictionary or "public" meaning of an occurrence and its personal or private meaning. The public meaning is the formal, objective definition of the event – devoid of personal significance or connotation. A boy is teased by his friends. The objective meaning of the event is simply that they are goading him. The personal meaning for the boy who is teased is more complex, for example, "They don't like me" or "I am a weakling."...Private meanings are often unrealistic because the person does not have the opportunity to check their authenticity. In fact, when patients reveal such meanings to their psychotherapist, this is frequently the first chance they have had to examine these hidden meanings and to test their validity. (pp. 48-49)
>
> In order to understand why the depressed mother would want to end her own life and that of her children, we need to get inside her conceptual system and see the world through her eyes. We cannot be bound by preconceptions that are applicable to people who are not depressed. Once we are familiar with the perspectives of the depressed patient, her behavior begins to make sense. Through a process of empathy and identification with the patient, we can understand the meanings she attaches to her experiences. We can then offer explanations that are plausible – given her frame of reference." (pp. 15-16)

from the subjects' frame of reference, rather than merely giving conventional interpretations to the things they say.

Cognitive Therapy is also like most other forms of psychotherapy in that it uses both reason and demonstrations to persuade people to take up better views and ways of living. In one form or another, most therapists use reason to analyze and attempt to disabuse clients of some of their most harmful and unfounded views, whether it is through direct argumentation or by using "reverse psychology," though as we're about to see, cognitive-behavioral therapy does this much more explicitly than most forms do. And like most helpful therapists, the cognitive therapist demonstrates by his or her relationships with clients that they are at least tolerable human beings, and by serving as a role model, he or she also demonstrates how a relatively well-balanced person can interact with others and look upon people and the world.

The core elements of Cognitive Therapy, then, are common to the other major psychotherapies. So what makes it special? Cognitive Therapy differs from other forms in being more here-and-now oriented, directive, and argumentative than the approaches that encourage the patient to dwell on past injustices or to meander on about their childhood or dreams. Instead, it targets the hyper-critical, self-castigating thoughts that are implicated in our psychological difficulties – the "cognitive triad" discussed earlier – and ironically it *uses* criticism to identify and correct the problem, rather than simply relying upon the therapist "being there" for their clients, or hoping that the problem works itself out as soon as the client becomes aware of it. In short, there's more "working through" in Cognitive Therapy – written exercises of it, in fact, as we'll now see.

As one might expect from its name and its emphasis upon cognition, Cognitive Therapy is set apart from other psychotherapeutic approaches by its reliance upon *reason* as a therapeutic tool to help understand and overturn the negative and irrational thinking behind people's psychological problems. As I mentioned, this should all sound familiar to philosophers: cognitive therapists analyze people's thinking for faulty logic, and they use reason to attempt to persuade them to adopt sounder or more healthy views, just as philosophers do. Cognitive Therapy is positively dialectical, in fact, and its major spokesemen explicitly invoke Socrates as the paradigmatic exemplar of the cognitive method.[458]

Socrates, recall, thought that a great deal of evil and suffering was the result of ignorance and mistaken and confused ideas. When people's dogmatism became too tyrannical and harmful, he tried to show the wisdom of leading a more examined life by applying reason to some of our most deep-seated but somewhat clouded views (such as "the Gods want us to punish people who do ***x***") to determine whether they had any real or rational foundation we should be acting on. Similarly, as we've just seen, cognitive therapists maintain that depressives suffer from their unexamined dictatorial "automatic thoughts" and hyper-critical and perfectionistic schemas, so their goal is to try to literally change people's minds, by modifying the influence of these negative views through rational scrutiny and persuasion. Beck (1976, pp. 269-70) explains the process for us here:

> The patient takes his assumptions and constructs so much for granted that he usually is unlikely to articulate them until he is pointedly questioned about them. The therapist helps the patient to make

[458] See Ellis *et al.*'s (1985) preface; or Beck (1976, pp. 269-70), which is reproduced in my text.

> explicit the assumptions underlying his behavior and then, working together, they scrutinize, probe, and test these assumptions.
>
> Challenging the basic assumptions is important in treating patients, such as depressives, whose cognitive organization is essentially a "closed system." The system does not accommodate contradictory information. The postulates are accepted as facts. Improvement is related to opening the system to new information and different points of view. Moreover, the specific cognitive schemas become more elastic and permeable.
>
> Through questioning, a particular assumption may be subjected to argument. The procedure consists of: (1) eliciting the patient's reasons for believing the depressogenic assumption, (2) marshaling, as in a debate, the evidence in favor of or contradictory to the assumption. The notion, as in the Socratic dialogues, is to find the "truth" through verbalizing the opposite position on a given issue.

Not only does Cognitive Therapy have affinities with the Socratic dialogue, but it also has elements in common with the Stoic philosophy of attempting to master one's destiny and emotions by tempering one's desires and expectations, as we'll see in the next subsection. Moreover, although they don't actually label it this way, cognitive therapists actually situate themselves squarely within the logico-empiricist tradition, as when Beck and Rush (1978, pp. 205-206) liken Cognitive Therapy's methods to teaching the scientific method of hypothesis testing that we in philosophy call the "H-D" or Hypothetico-Deductive method:

> The therapist and patient collaborate to use an empirical methodology to focus on specific problem areas. The therapist must clearly understand the patient's conceptualizations of himself and the world around him. In essence, he must be able to see the world "through the patient's eyes." If the patient's conceptualizations differ from the therapist's views of reality, the collaborators tend to reconcile the differences with a logical empirical approach.
>
> In essence, the patient's thoughts are treated as if they were hypotheses requiring validation. During this validation process (often conducted as homework), the patient needs to clearly understand what beliefs or ideas (hypotheses) are being tested ....Technically, cognitive therapy may be compared to a scientific investigation: (1) collecting data that are as reliable as possible; (2) formulating hypotheses based on the data; and (3) testing and, if indicated, revising hypotheses based on new information.

As Beck and Rush (1978, pp. 206-07) go on to explain, the data of the investigation consist of the patient's "automatic thoughts," feelings, and wishes. The therapists elicit the negative attitudes surrounding the events that upset the patient, and set about engaging subjects in examining their validity and "reality-testing" their probable truth-value.

As Beck (1976, p. 20) explains (citing his 1967, p. 318), it's these sorts of processes that earn cognitive/behavioral therapy its "cognitive" classification, due to its operative assumption that

> ...psychological problems can be mastered by sharpening discriminations, correcting misconceptions, and learning more adaptive attitudes. Since introspection, insight, reality testing, and learning are basically cognitive processes, this approach to the neuroses has been labeled cognitive therapy.

But as Beck mentioned before, this isn't all just conducted at the abstract level – the therapist initiates a program of applying their insights and more positive ways of thinking to the patients' immediate lives. This brings us to its "behavioral" aspect.

To counteract subject' pessimism about the future and their sense of hopelessness and helplessness, cognitive therapists use concrete homework assignments to demonstrate to them that they *can* perform elementary tasks and that they're not useless or worthless. For example, the

therapist will encourage his withdrawn client "Go ahead and go for broke and ask her for a date! What have you got to lose?" As Beck (1976) explains, this process of planning and assigning some program of concrete activity is called "mobilizing" the patient, and it targets some of the major symptoms of depression and can prove very beneficial.[459] Therapeutic hours are run as tutorial sessions, consisting largely of going over the results of these assignments, emphasizing how the positive results invalidate their former ways of thinking, or analyzing where the patients went wrong if something backfired. Again, the usual method is to identify the negative thinking underlying their failures or disappointing performances, and to examine its validity and attempt to nullify or overturn it.

In addition, cognitive therapists may undermine subjects' self-criticism by turning the tables through role-playing, as Beck (1976, pp. 293-94) explains: "The therapist, for example, plays the role of the patient as he sees himself: inadequate, inept, weak. The patient is coached to assume the role of a harsh critic who will verbally attack the 'patient' for any demonstration or acknowledgement of a fault." This exercise is useful in revealing to subjects that they don't ordinarily judge others as severely as they do themselves, and that many of their self-criticisms are unreasonable or even outrageous when others make them, and so, like the other techniques of cognitive therapy, it "helps the patient to identify his warped thinking and to learn more realistic ways to formulate his experiences" (Beck 1976, p. 20). And finally, Cognitive Therapy also explicitly employs certain behavioral techniques and homework assignments to demonstrate that some of the clients' worst perceptions and fears and worries are unfounded: they even have to practice their scales at home! (See, e.g., the Appendices in Beck at al. 1979.)

That's the thumbnail version of Cognitive Therapy and its theoretical rationale, then. It's an approach that makes a lot of sense, because it doesn't throw away good data concerning our pessimistic views and inferences, or obsess on hidden motivations, Oedipal fixations, or castration complexes. Instead, it concentrates on the maladaptive cognitions within subjects' threshold of awareness that keep them depressed, and it urges them to take up reason to overturn these ways of thinking, and it only stands to reason that we can only master our thoughts and feelings by becoming more aware of what they are and thinking them through. But now let's consider the potential adverse effects of this type of approach.

On The Ethics of Cognitive Therapy

[459] Beck (1976, pp. 274, 279) explains, "There are many positive advantages from a rationally designed activity program. Some of these are: (a) The patient's self-concept is changed. He sees himself as more masterful and less inept. Concomitantly, with the improvement in his self-concept, he becomes more optimistic. (b) He is distracted from his painful, depressing thoughts and his painful affect by transferring his attention to the activity. (c) Other people's responses to the patient become more positive; "significant others" generally reinforce the patient's constructive activity in a beneficial way. (d) There may be a change in his affective response; he begins to enjoy the activities and thus feels better....In order to help mobilize a patient into activity, the therapist must first elicit the patient's reasons for his inactivity....The usual reasons given by depressed patients for their passivity, inertia, and resistance to engaging in a project are: (a) "It is pointless to try." (b) "I cannot do it." (c) "If I try anything, it won't work out and I'll only feel worse.""

Because my defense of intentional psychology is premised on the claim that its applications do more good than harm, I must also address the ethical concerns about cognitive therapy and psychotherapy in general.

Let's start with the former. Most psychotherapists attempt to get subjects to accommodate their attitudes to the harsh realities of the world, but cognitive therapists especially like to quote the maxim of the Stoic philosopher, Marcus Aurelius: "If thou are pained by any external thing, it is not this thing that disturbs thee, but thine own judgment about it. And it is in thy power to wipe out this judgment now."[460] However, there are some bothersome aspects to this attitude: instead of trying to change the world when things aren't going right, it counsels that we lower our expectations, so we won't *mind* so much; that not only seems too relativistic (if it's suggesting that things are only wrong or unjust because we think they are, and if we change our mind they cease to be so), but it also sounds defeatist ("Don't try to change things, just change your attitudes about them"). These are legitimate concerns, which warrant a reply.

It's easy to take Stoicism the wrong way, as counseling that we should have the patience of Job, without even offering us the assurance that there is a God to be faithful to. People forget that Stoicism was a moral philosophy more concerned with mental health and well-being than is the prohibitive Judeo-Christian framework. At any rate, therapists are not offering a moral theory; narrow psychology *per se* does not judge what is right or wrong or good or bad. Clinicians do help clients determine that certain of their values and beliefs are unrealistic or maladaptive, but this is quite compatible with moral realism, the view that some things really are right or wrong independently of our opinions about them. In fact, many therapists subscribe to a Utilitarian theory, judging that someone's attitudes are wrong *because* they are harmful. Moreover, in most cases therapists are not trying to get people to condone murder or other atrocities, they are simply trying to prevent them from being so bothered by the neighbours and co-workers; but when they do treat people who are disturbed by their role in atrocities, the individuals in question have usually been engaging in self-destructive behavior to such an extent that, as Hendin (1983, p. 97) puts it describing one veteran, "The 15-year tormented sentence he has served in his own prison is probably harsher than any he would have received had he been punished for anything he did."

As for quiescence, cognitive therapy doesn't counsel sitting back and doing nothing – it tries to overcome subjects' apathy by encouraging them to live more active and rewarding lives, unencumbered by their negative ways of thinking. The point is, in many cases of clinical depression, it's not the world that is at fault in keeping us miserable, it's our pessimistic attitudes, and things will just get worse for us if we don't try changing them; e.g., as Beck and Rush (1978, p. 203) point out, "if the patient incorrectly *thinks* he is being rejected, he will react with the same negative affect (e.g., sadness, anger) that occurs with *actual* rejection," and this kind of attitude is likely to be a self-fulfilling prophecy, but if we responded more positively, the world might follow suit. Of course, in some cases, the world was the original source of the problem, all right, but what's done is done, and the wisdom of Stoicism is that the key to mental health is to accept those facts we cannot change. Sometimes we have to accommodate ourselves to the past, instead of continuing to agonize over it; e.g., as we saw in Part II, therapists have to get incest

[460] Aurelius is quoted in Beck (1976, p. 263); Ellis (1961, pp. 56-57) and Ellis (1985, p. 9). In his *Control Therapy*, William Glasser (1984, p. 181) also emphasizes that we can't control the world, just our response to it.

victims to realize that they were victimized, that they weren't responsible for their abusers' behavior, and that they should stop blaming themselves for it.

Psychotropic therapies, on the other hand, are actually a lot worse on the "Don't change the world, change your attitude" score. At least cognitive and family therapies try to bring about some fundamental changes by addressing the conflicts in our attitudes and interactions that aggravate us. But somatic therapies try to stop us from being so bothered by things in a different way: they tranquilize us. Keeping people on addictive drugs such as Valium[461] those "Mother's Little Helpers" which are dispensed in the billions in contemporary society,[462] is a far more insidious practice than providing them with psychotherapy, and constitutes a far greater assault on subjects' personal autonomy. Their spouses still behave cruelly toward them, or their bosses are still – literally – a pain to them, but under the influence of tranquilizers, they won't mind so much.

Still, in many ways, the world *is* a source of woe, and we'd have to be insensitive or ignorant *not* to be distressed by it; does cognitive therapy say we should shut off the news and turn a blind eye to such things, or con ourselves into thinking that things aren't so bad? Well, no – cognitive therapy is not a blanket attempt to whitewash or smother all unpleasant facts. It doesn't say that we as a society shouldn't do something about the evils of the world. Ignorance is not bliss, especially when dealing with nuclear stakes, or other toxic substances. Instead of merely trying to placate and soothe the terrified subject, a therapist can tell him to channel his fears into constructive activities by joining Greenpeace or other such movements.

Two further ethical issues to consider involve deception and manipulation. Therapists try to convince depressed people that their negative thoughts about themselves are mistaken and should be changed, but the psychologists Lauren Alloy and Lyn Abramson argue that depressives might actually be sadder but wiser, since they have a more accurate assessment of whether they are in control (in a certain experimental situation involving a green light and some buttons for subjects to push, at least[463]). Moreover, some critics, such as Jeffrey Masson,[464] charge that there is probably always some violation of autonomy in psychotherapy, whether it is intended to be benign or not, since the therapist is trying to produce changes by "talking people into and out of things," as Freud described it in a letter to Fleiss (quoted in Szasz 1978, p. 109).

Let me deal with the deception charge first. While I grant that depressed subjects may sometimes have more accurate perceptions and that many 'normal' subjects may very well have overinflated ideas about their own capacities, neither of these points shows that depressives aren't self-deceived about how lousy they are, nor are they enough to undermine Beck's observations that

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[461] See, e.g., Swonger and Constantine (1983, p. 277): "There is no doubt that addiction can occur with the use of all the anxiolytic [anti-anxiety] agents; most instances, however, involve either excessive doses or duration of use beyond two months. Dependence of both a psychological and a physical variety develops, and abstinence phenomena similar to those of alcohol and barbiturates ensue on withdrawal."

[462] Stephen Schoonover (in Bassuk *et al.* 1983, p. 3) reports that as of 1983, U.S. physicians "still write about 100 million prescriptions for sedative-hypnotic agents each year, of which 60 million are for the benzodiazepines (chlordiazepoxide [Librium] and diazepam [Valium] account for about 75%)."

[463] For a description of Alloy and Abraham's 1979 experiment, see, e.g., Rosenhan and Seligman (1984, p. 310).

[464] See Masson's *Against Therapy* (1988), or his interview in the San Diego *Reader*, Feb. 2, 1989, pp. 14-18.

they often draw arbitrary inferences in accordance with their negative self-images. However well they may do in the narrowly circumscribed test situation, depressed peoples' thinking is systematically distorted when it comes to their own lives; e.g., as Beck (1967, p. 240) notes:

> Evidence of deviation from logical realistic thinking was found at every level of depression from mild neurotic to severe psychotic. The ideation of depressed patient differed from that of the non-depressed patients in the prominence of certain typical themes, viz., low self-evaluation [e.g., "A brilliant academician questioned his basic intelligence, an attractive society woman insisted she had become repulsive-looking" (p. 231)], ideas of deprivation, exaggeration of problems and difficulties, self-criticism and self-commands, and wishes to escape or die.

As for the manipulation charge, psychotherapists must grant that persuasion is an integral part of their "Persuasion and Healing" process (as Frank 1961 terms it), and also that persuasion employs rhetoric. But is rhetoric *ipso facto* deceptive and manipulative, or can it be, as they say nowadays, "empowering"? As Szasz (1978, pp. 20-21) notes, rhetoric is not all bad or sophistry: there can be good rhetoricians, too, who liberate subjects by providing them with more self-understanding and increasing their ability to solve their own problems (instead of being too dependent upon other people or too reliant upon drugs). And as Szasz (1965, p. 17) argues in his *The Ethics of Psychoanalysis*, psychotherapy between consenting adults is in the freedom game, for it liberates subjects from the tyranny of their super-egos, and helps to dispel the irrational and autonomy-damaging ideas that were drilled into them as a child, before they were capable of analyzing them critically. Peter Breggin, another psychiatrist who is greatly concerned with personal autonomy, argues similarly in his *The Psychology of Freedom* (1980).[465] This is in close alignment with the position of the Frankfurt School and Critical Theory, which also hold that certain interpretive and critical analyses of the attitudes keeping individuals or groups oppressed are often needed to enable them to achieve rational self-determination (see, e.g., Fay 1975, esp. pp. 97-105), so the charge that rhetoric or critical analysis fundamentally undermines subjects' autonomy seems to be unfounded.

In fact, cognitive-therapy is so amenable to self-help treatments for the very good reason that it enables people to solve their *own* problems through the use of their own powers of reason, thereby maximizing autonomy, not interfering with it. As Beck (1976, p. 3) puts it, the central insight of cognitive therapy is,

> *Man has the key to understanding and solving his psychological disturbance within the scope of his own awareness*. He can correct the misconceptions producing his emotional disturbance with the same problem-solving apparatus that he has been accustomed to using at various stages in his development.

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[465] Breggin (1980, pp. 125-28) offers some criteria for determining when guilt, shame, and anxiety are irrational:

"Self-criticism that reeks of self-loathing must be treated as alien and irrational. So, too, a sense of doom or dread is rarely useful to the individual and instead must be handled by seeking out and dealing with any real, underlying fear. Usually, the doom or dread is not contained within the current situation but originates in childhood helplessness.

Second, if the negative feeling has a long past history, it is probably not a form of legitimate self-criticism or realistic fear. The person who says, "I've always been a jerk; that's why I hate myself" is very likely wrong in his or her perception of reality. More likely, the person was badly oppressed in childhood and then learned a lifestyle of helplessness. Similarly, if you have "always been afraid" of something, you probably have a lifelong anxiety rather than a legitimate fear.

...Third, negative feelings that are associated with many different aspects of daily life probably reflect a lifelong pattern of self-defeat and self-oppression. Fourth, guilt, shame, and anxiety that seem out of proportion to the apparent cause are probably caused by something entirely different."

If people can learn to do this on their own just using books, great, but if not, they can benefit immeasurably from the assistance of someone who can educate them about better ways of thinking. But even if depressed subjects are not actually deceived about themselves, and even if their current beliefs represent their considered and autonomous judgments rather than something they were brainwashed into while quite young and impressionable, I submit that cognitive therapy directed at giving them more constructive attitudes is morally acceptable, on Utilitarian grounds. Doctors are sometimes justified in administering placebos to make us better, thus employing deception, and therapists must sometimes resort to flattery, white lies, and benign illusions, to help people lead more fulfilling lives and relieve their suffering.

The area I worry about most with respect to therapists' ability to manipulate patients, however, is when psychiatrists use just as much psychotherapy as they need to in order to secure patients' trust and convince them to comply with physical therapies, which have had a pretty dreadful history, all in all. This pervasive practice in psychiatry seems to be a *violation* of trust, unless the doctors concerned have good grounds for thinking that the treatments are really needed or safe. As we've seen, however, neuropsychiatry still doesn't have good evidence for antidepressants' therapeutic rationale, and the answer to the query, "Is it safe?" is, "No – antidepressants have significant hazards." Consequently, Dr. Breggin's own practice seems to be preferable: he provides only psychotherapy, not pharmacotherapy, despite the fact that he is licensed to do both; he doesn't abuse his position of trust by convincing patients to medicate themselves into submission with their families or jobs, nor does he try to prohibit his patients from taking them, either – he leaves it a matter of personal choice, as it should be (see Breggin 1980, p. 133).

That much said about the ethics of cognitive therapy and psychotherapy in general, let me close by summing up my case in their defense.

Concluding Arguments in Defense of Intentional Psychology

According to the best available evidence, neuroeliminativism, considered as both a descriptive and a normative position, is ***wrong*** on two counts: in supposing that we should want to be rid of "folk" or intentional psychology in the first place; and in apparently recommending that medicine should restrict itself exclusively to drugs or other somatic "therapies," in the second.

We started with the evidence for the first claim: contrary to popularized misconceptions, psychotherapy can be much more effective than its critics have contended, even in the treatment of *bona fide* "mental illnesses" such as depression, since it turns out that psychotherapy and pharmacotherapy are comparably effective for the majority of cases. Then, to demonstrate why it is reasonable to suppose that the intentional approach is appropriate in this domain, in Section 7.3 I described Cognitive Therapy and the psychosocial model of depression. As for the neuroeliminativistic prescription or prediction that neuroscience should one day totally supplant intentional psychology in scientific and/or medical contexts, I detailed the some of the limitations and adverse effects of the neurobiological approach in Section 7.2. However, there are still a few loose ends to tie up in connection with the eliminativists' adversarial stance, which conflicts with medicine's more eclectic or pluralistic orientation. This final Section will directly address these

latter issues surrounding the futures of intentional psychology and neuropsychology, and conclude my defense of the former.

Eliminating Eliminativism: Why the Intentional and Neuropsychiatric Approaches Are *Both* Needed

Contrary to the eliminativists' suggestion, this doesn't need to be an *either/or* choice as so many philosophers' issues seem to be, because there is plenty of room for both paradigms and professions to co-exist in our society. In fact, I submit that it would be bad policy for applied medicine – which justifiably employs tools from many different traditions, just so long as they get the job done – to try eliminating either approach, for two important reasons. First, neither one is suited to everyone: both have counter- or contra-indications, and each is needed to treat the patients the other cannot. And second, even the pharmacotherapy advocates themselves concede that ***both*** approaches are frequently indicated, i.e., that drug treatments should be accompanied by psychotherapy in many cases, if only to ensure that patients comply with their treatment, and possibly to get enhanced symbiotic effects, as well. Consequently, there is no call to eliminate either the intentional or the neurobiological approach.

Let's consider each of these points in turn, starting with the fact that each kind of treatment is indicated where the other is contraindicated. Due to their propensities to cause side-effects, most somatic treatments have *contraindications* which make them off-limits for some groups of people, and this is certainly true for psychiatric drugs. The tricyclics we looked at are avowedly too dangerous for the weak-hearted (since they can induce fainting and cardiac arrests), and they shouldn't be taken by those who plan to ingest alcohol (because of the risk of dangerous interactions), and people with pre-existing health problems who're already taking medications (such as stimulants or sympathomimetics for their hearts, or the antacid cimetedine for their stomachs) should avoid them, as should pregnant women (because of the risk of inducing birth defects such as limb deformities[466]) and people with glaucoma (because they can induce further retinal changes and even blindness), while others are just plain allergic to them, and can't take them because they produce horrible rashes.[467] But I especially want to focus on the ***elderly*** patient population in support of this point about the contraindications of antidepressants, because they are particularly susceptible to the side-effects, an enormous number of people are involved, and the problem's only going to get worse as America's demographics shift and it becomes ever more dependent upon drugs for its problems. Accordingly, let's take a moment to consider the problem of geriatric medicine.

Antidepressants and the Elderly

Although they're not *absolutely* contraindicated for this group across the board, we should be prescribing antidepressants to older patients as little as possible, since they are especially

[466] Thalidomide, recall, was a psychoactive drug intended to relieve anxiety; it is classified as a sedative/hypnotic by A. D. Korczyn in *Meyler's Side Effects* (Dukes 1980, p. 69). See Mintz (1965) or Pekkanen (1973) concerning the thalidomide tragedy and how it was narrowly averted in the U.S., and see Barbara Ameer, "Teratology of Psychoactive Drugs," in Davis and Greenblatt (1979, p. 10) concerning more recent reports of limb deformities.

[467] Concerning these counter-indications of antidepressants, see, e.g., Law & Foltz (1990, p. 182), or Griffith (1989, p. 997).

susceptible to their adverse effects, particularly the anticholinergic effects and the movement disorders. Younger patients are better able to tolerate neuropsychiatric drugs, but the elderly are far more prone to their side-effects, for two main reasons. The first problem is people metabolize and excrete ingested substances less quickly and efficiently as they get older because their livers and kidneys don't work as well, and as a result, drugs stay in their systems longer, tolerance decreases, and more side-effects result.[468] The second problem is that psychiatric drugs can have dangerous interactions with other medications, but older people are far more likely to be taking other medications for their various chronic ailments. Lazarus (1979, p. 17) points out that most elderly Americans suffer from at *least* two chronic illnesses for which they're taking medication, and moreover many see several doctors at once without telling the others. Taken together, these factors account for the fact that both the physical and the psychological side-effects of neuro-psychiatric medication are especially pronounced in older patients. Let's start with the former, concentrating once again on tricyclics (since Prozac is generally recommended only after the other types of antidepressants have been tried, for the reasons connected with its long half-life which were outlined earlier).

Older patients are more prone to tricyclics' autonomic anticholinergic effects such as constipation, which can sometimes escalate to very serious conditions such as paralytic ileus (or the complete inability to evacuate) in the elderly.[469] And the postural hypotension they induce, which is particularly bad with imipramine, is especially a problem for this age group, since it results in fainting and falls, which can cause head traumas, or break their brittle bones, leading to fatal complications such as pneumonia.[470] Psychotropic drugs in general also tend to produce more movement disorders in older patients, who already have problems with motor coordination; e.g., Lazarus (1979, pp. 20-21) reports that such drugs afflict 50% of those 60-80 years old with some kind of movement disorder, and this is corroborated by Crane.[471] TD in the oral region can be much more worse for the elderly (who are more likely to need dentures they won't be able to wear because of the disorder, for one thing[472]; and because they aren't generally as strong, the

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[468] See, e.g., Holzman (1988b, p. 52) about how older people's livers and kidneys don't work so well, so the drugs aren't excreted as efficiently, and so they stay in their systems longer and produce more side-effects; or Bassuk and Schoonover (1983, p. 16); or A.D. Korczyn, "Hypnotics and Sedatives," in Dukes (1980, p. 63), who notes, "Old people have a low lean body mass, multiple diseases, and reduced reserves of organ functioning. Inactivation of drugs may be slowed as well as their excretion. Special care is therefore required in the administration of drugs to the elderly."

[469] Concerning the paralytic ileus or paralysis of the bowel wall induced by psychoactive drugs, see, e.g., Shrader and DiMascio (1970, p. 262), on this and other gastrointestinal problems.

[470] See, e.g., Davis (1985, pp. 1506-07); Shrader and DiMascio (1970, p. 265); Schoonover *et al.* (1983, p. 304); Georgatos and McCue (1986, p. 374); Lazarus (1979, p. 20); or Korczyn (1980, p. 82) concerning the hazards of hypotension for the elderly.

[471] E.g., see G.E. Crane, "Factors Predisposing to Drug-Induced Neurologic Effects" (in *Advances in Biochemical Psychopharmacology*, Vol. 9, *Phenothiazines and Structurally Related Drugs*, I.S. Forrest, C.J. Carr, and E. Usdin, eds. New York: Raven Press, 1974 pp. 269-279); as Crane (1978, pp. 170-71) notes, the aforementioned survey of "a chronic hospitalized mental population revealed the presence of adventitious movements or postural disorder in about half of the patients aged 55 or over."

[472] Here Crane (1978, p. 179) elaborates on the problems TD poses to the elderly, including the fact that neck spasms can develop that can prove fatal:

"Complication are usually found in the buccal region. Ulceration of the tongue, inflammation, severe dryness of the mucosae, drooling, macroglossia [enlarged tongue], inability to wear dentures, loosening of the mandibular joints are some of the complications found in the oral area. In extreme cases, there is impairment of deglutition and respiration. These complications, plus violent, exhausting, flailing of the limbs, may be fatal in the very old and in those with

constant shuffling, tremors, twitches, or spasms that psychotropics cause can take a lot more out of them. But although all these physical effects are bad enough, the psychological effects of antidepressants on the elderly are even more worrisome, for they frequently greatly impair older people's autonomy, as well as their health, in two ways.

The first problem is sedation, which is widely reported to be a very frequent and pronounced side-effect of tricyclics on the elderly population.[473] Considering that sleeping disorders are one of the symptoms of depression in the first place, this hardly constitutes a cure, and it gives subjects far less control over their lives by making it difficult for them to even get out of bed. Secondly, they can cause outright delerium; as Edelstein (1980, p. 26) remarks, "Older persons are particularly sensitive to the provocation of *delerium* by any type of centrally acting anticholinergic drug. Such side effects variously take the form of anxiety, agitation, or frank hypnomania." It hardly needs to be said that such symptoms severely compromise one's capacity to live freely and make rational decisions, and that it is highly counter-productive to be administering psychoactive drugs in the name of mental health when they wind up producing the very sorts of neurochemical imbalances they are supposedly rectifying.

Because of these effects, antidepressants are frequently counter-productive for the elderly patient population, since they were meant to relieve their depression and make them more active, but they end up making them sleep all the time or even inducing senility, instead. Consequently, it is inappropriate to be treating the elderly's psychological problems with medications, especially considering *why* they're depressed in the first place. In quite a number of cases, the problem is due not to biological changes so much as to changes in their lives and social interactions. The evidence for this comes from a number of fronts, as Blazer (1982, pp. 88-89) explains:

> First, most mental disorders in late life are first-time events (Post, 1968; Slater and Roth, 1969), which is contrary to the assumption that genetic factors play a major role in the development of these disorders. Persons with late onset depression also have a family history of affective illnesses less often than do persons with early onset depressive illness (Chessea, 1965; Hopkinson, 19[6]4).[474] Second, the elderly face increased social and economic pressures secondary to transitions in late life, such as prejudice, declining incomes, and impaired physical health (Bengston and Haber, 1975; Palmore,

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extensive arteriosclerosis. Retrocollis [spasms in the back of the neck] and muscual rigidity of the elderly is fatal. Truncal dyskinesia and dystonia may cause the patients to fall and sustain fractures."

[473] See Georgotas and McCue (1986, p. 375), or Schoonover (1983, p. 298) regarding the increased sedative effects of antidepressants on the elderly.

[474] Blazer (1982, p. 56) elaborates on the point that late-onset depressives have less of a family history for the disorder:

"Considerable evidence suggests that the genetic contribution to depressive disorders in late life is weaker than that at other stages of the life cycle (Hopkinson, 1964; Mendlewicz, 1976, Schulz, 1951). Hopkinson found the risk for immediate relatives of patients whose onset of depression occurred later than 50 years to be 8.3% as compared with 20.1% for the relatives of patients whose onset occurred earlier. Schulz found the risk for parents of depressed individuals with late onset depression to be 9.3% and 15.7% for parents of those with early onset. One would expect the risk for relatives to decrease with late onset depressive disorders. Genetically determined factors should initiate their influence before late life, and environmental pressures accumulate with time."

Blazer is referring to G. Hopkinson, " A Genetic Study of Affective Illness in Patients Over 50" (*British Journal of Psychiatry* 110, 1964, 244); J. Mendlewicz, "The Age Factor in Depressive Illness: Some Genetic Considerations" (*Journal of Gerentology*, 31, 1976, 300); and B. Schulz, "Auszahlunger in der Verwandtschaft von nach Erkrankungslater und Geschlecht pruppierten Manisch-Depressinen" (*Archiv fur Psychiatrie und Nervenkrankheiten* 186, 1951, 560-76).

> 1969). Third, older people may be more susceptible to the deleterious effects of social stress (Caudill, 1958; Lazarus, 1966).[475]

As Blazer (1982, p. 90) explains, some of these social stressors the elderly are subjected to include

> ...attempts to force them into a preconceived cultural "definition" as dependent, roleless, querulous, forgetful, fretful, and irritable. "Ageism" describes this prejudice toward the elderly. Again, loss of status and prestige accompanies the absence of roles in late life. Rolelessness among the elderly is secondary to retirement from formerly productive roles and the absence of many socially prescribed roles for elders. Accompanying the loss of employment and roles is the parallel loss of economic status. Economic adversity secondary to lower income is quite common in later life. The elderly are also at greater risk for loss of spouse, siblings, friends, and even children.[476]

Similarly, Brown (1985) reports,

> Poverty, declining status and prestige associated with retirement, loneliness and isolation relating to loss of spouse, relatives and peers, declining faculties and reduced physical strength, and anticipation of their own death contribute to depression in the elderly.[477]

When we toll some of these factors up, between enforced retirement, watching their savings dwindling away, seeing their friends getting sick or dying, and being shunted off themselves to nursing homes by their seemingly ungrateful and unloving children and society,[478] the elderly

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[475] The remainder of Blazer's (1982) references to back the contention that social factors are responsible for many cases of depression in the elderly are to:
F. Post, "The Factor of Aging in Affective Illness," in *Recent Developments of Affective Disorders, British Journal of Psychiatry*, special publication no. 2, 1968, A. Oppen and A. Walsh, eds. 1968).
E. Slater and M. Roth, *Clinical Psychiatry*, ed. 3.Baltimore: Williams & Wilkins, 1969.
E.S. Chessea, "A Study of Some Aetiological Factors in the Affective Disorders of Old Age," Ph.D. dissertation, Institute of Psychiatry, University of London, 1965.
V.L. Bengston and D.A. Haber, "Sociological Approaches to Aging," in D.S. Woodruff and J.E. Birren, *Aging*: *Scientific Perspectives and Social Issues*, New York: Van Nostrand Reinhold, 1975.
E. Palmore, "Physical, Mental, and Social Factors in Predicting Longevity," *Gerontologist* 9, 1969, 103.
W. Caudill, *Effects of Social and Cultural Systems in Relation to Stress*', pamphlet no. 14, New York: Social Services Council, 1958.
R.S. Lazarus, Ps*ychological Stress and the Coping Proces*s, New York: McGraw-Hill, 1966.

[476] The list of "predictable stressful life events in late life" offered by Blazer (1982) is culled from R. Butler, "Old Age," in *American Handbook of Psychiatry*, vol. 1, ed. 2, S. Arieti, ed. (New York: Basic Books, 1974).

[477] See Peter J. Brown, "Emotional Illness in Old Age," in *Psychiatric Nursing* (Annie T. Atschul, ed. Edinburgh: Churchill Livingstone, 1985). In support, Brown cites: A.M. Storrs, *Geriatric Nursing* (London, Balliere Tindall, 1976); W.C. Chenitz, "Primary Depression in Older Women: Are Current Theories and Treatment of Depression Relevant to this Age Group?" (*Journal of Psychiatric Nursing and Mental Health Services* 17: 1979, 20-23); C. Eliopoulos, *Geriatric Nursing* (London: Harper and Row, 1979); F.G. Ebaugh, *Management of Common Problems in Geriatric Medicine* (Menlo Park, Ca.: Addison-Wesley, 1981); and M.S. Wantz and J.E. Gay, *The Aging Process: A Health Perspective* (Massachusetts: Winthrop, 1981).

[478] To explain why those in their late 50's seem to have a higher incidence of symptoms of poor physical and mental health as compared to those in their 40's, the social psychologists Leo Srole and Thomas Langer (1978, pp. 230-31) elaborate on some of the factors which have been noted in the text – the former are generally faced with four major life changes which undermine their happiness, self-esteem, and drive:
"First, there is the change to an emptied, fundamentally "broken" home and a greatly shrunken range of parental activity. Among its other psychological functions, the parental role is generically akin to an institutional "office," into which is poured a considerable investment of personal identity and sentiment. Both roles carry leadership responsibilities that are ego buttressing and stabilizing, and both leave voids difficult to fill when they are lost. Second, if the marital relationship between the parents has previously been less than mutually equilibriated, the void tends to bring out old and new strains as the couple face their change of family life alone.

often score five or six out of six on Brown and Wallace's (1978, pp. 103-4) list of ego-threatening events that can precipitate depression that was discussed earlier.

The solution to these troubles isn't to make the elderly prematurely senile with drugs, but that's just what we're doing, at a prodigious rate, not only with anti-depressants, but also with full-scale major tranquilizers such as Haldol.[479] Instead of doping up the aged to make them more tractable and strapping them to geriatric chairs (as is often done[480]), counselors should be working with them on a one-on-one personal basis, and there should also be group activities and full-scale recreational programs available to them, to help them restore their self-worth and sense of identity in some community, to get them more engaged in life, and to stop them from drifting from reality (*cf*. Lazarus [1979, p. 20]).

This is already a large problem, since studies have shown that between 16% and 35% of elderly subjects admitted to geriatric units for confused and abnormal behavior are suffering from the effects of psychoactive drugs.[481] And despite the fact that they constitute only 17% of the population, half of all the deaths from drug overdoses occurs to those over 60; reportedly

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Third is the anthropological fact that societies place differential value on the several age levels in the population. If China in its classical period was at one extreme in prizing the old over the new, especially in venerating the family's aged members, contemporary American society is probably close to the opposite pole in tending to equate "old" with "junk." Thus, when retired to the side lines as spectators of their children's own families, often under the implicit injunction that they should be seen but not heard, parents are aware that they have begun the slide of denigration in the eyes of important others.

Fourth, ...approaching death has come to be viewed not as the curtain rising to the life beyond but as the curtain descending with the absolute closure of "finis."”

[479] Far too many patients in intermediate and extended "care" institutions are being administered Haldol and other potent anti-psychotics, as well as minor tranquilizers and antidepressants (often in combination). As Beers *et al.* (1988, p. 3016) report in the *JAMA*, a study of Tennessee nursing homes found that 42% of the patients were receiving anti-psychotics (see W.A. Ray, C.F. Federspiel, and W. Schaffner, "A Study of Antipsychotic Drug Use in Nursing Homes: Epidimiologic Evidence Suggesting Misuse," *American Journal of Public Health* 70, 1988, 485-91), while Beers *et al.*'s own study of 12 representative Massachusetts nursing homes found that one-third had orders for, and 26% were actually receiving antipsychotics five or more days per month, despite the fact that only 15% had been diagnosed as psychotic, and 65% had been prescribed one or more psychoactive medication, frequently highly sedative ones. As Beers *et al.* (1988, p. 3019) comment, "Reliance on scheduled regimens of psychoactive medicines indicates that these drugs are not used transiently for periods of special need. Instead, this pattern of use is compatible with the concept of sedation as 'chemical restraint'."

[480] By some reports on the network news, about half of elderly inpatients in extended "care" homes are under some form of restraint, often to prevent them from falling and hurting themselves as the result of the hypotension caused by the medications. See Hal Willard, "At 90, the Zombie Shuffle" (*Newsweek*, Feb. 20, 1989, p. 10) for an account of one such case.

[481] E.g., Lazarus (1979, pp. 18-19) reports on a study saying that 16% of those with abnormal behavior admitted to a geriatric unit were attributable to psychotropic drugs; and according to reports in the A.P.A.'s own *Psychiatric News*, about 25% of the "psychiatric" disorders that occur in those over 65 are iatrogenic in origin, as VandenBos and DeLeon note (in VandenBos 1980, p. 250), adding that "drug-induced toxic states were identified by leading experts at a National Institute on Aging conference as the *prime* causes of the 'mental confusion' that is so often misdiagnosed as the beginning of chronic brain syndrome." Korczyn (1980, p. 63) comments on another study: “Thirty-seven of 136 patients over the age of 65 admitted to a psychogeriatric department were found to be suffering from conditions attributable to medication with psychoactive drugs. The effects seen included oversedation, confusion and disorientation, syncope, disinhibition, and aggressive outbursts.” And finally, we've already heard about Davies *et al.*'s study in Section 7.2 above (or see Breggin 1983, p. 172), which found that 35% of those over 40 receiving antidepressants get acute brain syndromes.

between 73,000 to 300,000 elderly Americans die each year from adverse drug reactions.[482] Moreover, the problem is only going to get worse, since it has been reported that fully half of the people who have attained the age of 65 or older are currently alive today; that means we're only really beginning to see the iatrogenic effects of medications on the elderly, and as the "greying of America" continues, we're going to have on the order of fifty million people taking extremely dangerous and irrational combinations of drugs for their various ailments, and we should be very cautious about adding psychiatric medications to the mix, considering that means such as psychotherapy are available to help deal with psychological problems.

The Limitations of Psychotherapy

Due to the contraindications and adverse reactions, then, not everyone who is depressed should be receiving antidepressant medication, particularly the elderly. Truth be told, though, the opposite is true, as well: psychotherapy's not for everyone, either.

The problem, which becomes painfully clear whenever someone tries to study the effectiveness of either form of treatment by randomly assigning subjects to different groups, is the drop-out rate. As DiMascio *et al.* (1979, p. 1455) point out here concerning their own study, it's a problem which afflicts both approaches, so it's a good thing that the other exists as an alternative:

> ... there were major differences in the patients' acceptance of different treatments. Of those subjects assigned randomly to psychotherapy, 32% dropped out before the first week. Early nonacceptance of treatment was lower in the groups offered pharmacotherapy, only 17% dropped out before the first week. Later, however, during the course of treatment, 25% of the patients in the pharmacotherapy-alone group discontinued their medication. Since the efficacy of drugs alone and psychotherapy alone was (sic) about equal, and both treatments were better than nonscheduled treatment, the patient who will not accept psychotherapy may be a good candidate for drugs alone, and vice versa.
>
> Patients who have marked vegetative complaints, particularly sleep disturbance, might find the pharmacotherapy most useful. Patients in whom the emotional complaints and mood disturbance override the somatic ones might find psychotherapy more useful.

Judging from these drop-out rates, then, I don't want to over-represent the powers of cognitive therapy, either. As we've seen, it uses reason to outflank the superego and drive out its nastier elements, but since not *all* psychological problems are due to over-active or hyper-critical superegos, of course, and since not everyone is amenable to reason, nobody is claiming that cognitive therapy will work for *every* kind of neurotic problem or every case of depression. Some people don't have the inclination or the capacity to engage in self-reflection and reasoning and personal dialogue with others, and others have a great deal of resistance to psychotherapy but might be willing to submit themselves to a more passive and medically sanctioned means of treatment (e.g., see Beck *et al.* 1979, 367 ff.).

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[482] The 73,000 figure was reported by the journalist Mike Masterson on the "*Geraldo*" show in 1989; see also Masterson (1989). Ironically, his is the more conservative figure; as Blazer (1982, p. 237) explains, "A recent subcommittee on long-term care of the United States Special Committee on Aging (1974) reported that drug misuse in such facilities caused 300,000 deaths and 1.5 hospital admissions annually. The cost of hospitalization for drug interactions was close to 3 billion dollars per year." See the Subcommittee on Aging and Subcommittee on Long Term Care, U.S. Senate Special Committee on Aging, *Drugs in Nursing Homes: Misuse, High Costs, and Kickbacks* (supporting paper no. 2. Washington, D.C.: U.S. Government Printing Office, 1974).

Thus, each approach has its indications, to fill the void left by the other; but now let's see why they should often be used in ***combination***.

Adjunctive Psychotherapy

Even if neuroeliminativists convinced psychiatric medicine as a whole to stop using intentional psychology as a *primary* means of addressing and treating mental illnesses, it will still need to use it at least derivatively, for reasons I'll now explain. Even from neuropsychology's point of view, there are two important reasons for continuing to employ *both* methods: not only is psychotherapy frequently needed to supplement pharmacotherapy in order to secure compliance and get *any* results, but it's often also a good idea to use both methods in combination to achieve *better* results than either would have alone.

Let's consider the importance of compliance first. Reportedly, up to fifty percent of psychiatric patients have some degree of "drug reluctance,"[483] as it is called, ranging from taking less than the prescribed dosage, to refusing to take any at all. Obviously, even the best of drugs can't do us any good if we don't take them. Consequently, unless they are to *force* their treatments upon patients – which goes against everything this country is supposed to stand for, and would probably be anti-therapeutic, anyway – pharmacotherapists are often helpless, unless they can somehow win their patients' trust and talk them into taking their medications.

Patients in general, and depressed patients in particular, have a variety of reasons to be reluctant to cooperate with their doctors' treatments: some have to do with their depressed states of mind; while others are in response to the undesirable effects of the drugs themselves. Let's start with the latter. Given what we've seen about the side-effects of psychiatric drugs, it should come as no surprise that they are avoided to a considerable extent by patients who can't tolerate the sedation, nausea, jitteriness, or sexual dysfunctions they induce. "The simplest method of managing these problems," as the pharmacotherapists Cole and Bodkin (1990, p. 23), for example, put it, "is to reassure the patient that these effects are medically benign and to wait for them to resolve with time, as they sometimes do." In other words, doctors need to "Use a little psychology on 'em!" if they are to get anywhere with their preferred mode of treatment, and this involves finding out what their patients' attitudes and concerns are, and persuading them that the treatment is conducive to the patients' own best interests.

Clinicians have also found that there are nearly as many reasons necessitating some form of adjunctive psychotherapy to try to secure troubled patients' compliance with psychotherapy as there are for prescribing the drugs in the first place. Some of the same reasons that keep people depressed keep them from wanting to get better: the belief that they don't *deserve* to get better, for example, or the desire to *punish* themselves, or parental- or authority-figures by staying miserable, as Glaser (1978) explains in the note.[484] Similarly, as Bassuk *et al.*'s (1983)

[483] The incidence figures for non-compliance with psychotropic drug treatments range from anywhere between 25-30% (the average dropout rate for patients receiving active medication in controlled studies, according to Beck *et al.* [1979, p. 357]), up to 50% (see Breggin [1983, p. 170]).

[484] Glaser (1978, pp. 254-65), the Director of Adolescent Services at Springfield Hospital, explains some of teenagers' reasons for refusing antidepressants:

Practitioner's Guide to Psychoactive Drugs notes (on p. 7), "if the patient has a negative self-image or if those close to him disapprove of pharmacotherapy, compliance with treatment is often poor;" however, as we've seen, the former is arguably why most depressed patients are "sick" in the first place – because they have a negative self-image! In addition, thoughts such as "It's addicting," "I am stronger if I don't need medicine," "I am weak to need it (a crutch)," "I only need to take medication on 'bad days'," and, "I should feel good right away," frequently interfere with a beneficial course of treatment, as Beck *et al.* (1979, p. 372) note. In addition, many elderly patients are poor compliers, either because they are forgetful, or because they weren't adequately informed in the first place.[485]

To combat these tendencies, pharmacotherapists often need to schedule weekly or biweekly "clinical management" sessions, as we saw with the NIMH study, not only to monitor the patient's blood levels to detect problems themselves, but also to find out whether they are taking the drugs, discuss whether they are avoiding them for good reasons, and attempt to circumvent or wear down the bad reasons through the processes of reasoning and persuasion. Thus, one can't be a (successful) pharmacotherapist without being a middling competent psychotherapist first; consequently, even the most archly neuro-psychiatric schools and medical schools in general continue to train their doctors in approaches such as psychoanalysis and probably always will, to teach them how to identify patients' reasons for resisting treatment and help gain their confidence and cooperation. Moreover, as some commentators have argued, psychotherapy has always been an integral part of health care, and physicians would do well to incorporate it into their practices, partly to secure the patients' cooperation and activate the placebo effect, and partly to avoid lawsuits from alienated patients.[486]

"Medicine ordered by a doctor and given by a nurse or the mother means control by an adult, and refusal offers a convenient way to express rebellious feelings. Medicine is often refused after a quarrel with the parents or the hospital staff.

Psychotropic medication also connotes an attempt to force behavior changes, something which the youngster cannot or does not wish to do. It means thought control, action control, and thus a further decrease of self-determination.

The depressed youngster who feels unworthy of living or who seeks punishment, has no reason to take medication that will counteract his desire to die or to be punished. The angry adolescent who feels right about settling disputes by violence does not want to be robbed of this power by tranquilizing medication.

For the drug-oriented adolescent the use of psychoactive drugs means a conflict of messages. "You don't want me to take mind-altering substances which make me feel good, but you insist that I take your medicine, which also is supposed to affect my mind."

...In spite of anticipatory explanations about the delayed effects of anti-depressive medication, the impatient and impulsive depressed adolescent often refuses medication after a few days. To him it is further proof that nothing will help him."

[485] As Blazer (1982, p. 237) explains, citing a study by D.V. Lundin ("Medication-Taking Behavior of the Elderly: A Pilot Study," *Drug Intelligence and Clinical Pharmacology,*12, 1978, 518),

"..the elderly are at much greater risk for medication errors. In one study of 50 individuals 65 years of age and older, 66% were taking prescription drugs without adequate instructions; 25% were not taking the prescription medications as labeled and directed by the physician. A breakdown of these medication errors revealed that 47% were errors of omission, 20% were errors of inadequate knowledge, 17% were self-medication errors, 10% were incorrect dosages, and 6% were errors of improper timing and frequency of drug intake (Lundin, 1978)."

[486] In her "Psychotherapy: A Medical Treatment," in Dongier and Wittkower (1981, p. 51), Vivian Rakoff writes,

"Dr. Robin DiMatteo, a psychologist from the University of California who produced evidence at the 1978 meeting of the American Psychological Association, produced evidence that patients who are dissatisfied with the technical outcomes of treatment most often bring malpractice litigation against their physicians if they are also dissatisfied with the social and emotional components of treatment. He went on to say, "Thus, even with all the technical skills of today's physician, it really does matter to patients that their patients be kind, considerate and caring...the process by which healing takes place is an interpersonal one." ...It is true that the listening, the human attentiveness, the verbal

But even in cases where the patients trust the doctor implicitly and their compliance is ensured, psychotherapy and pharmacotherapy are sometimes both indicated for another reason: to get the best results possible, if it turns out that they're more effective in combination than either is alone. Some studies suggest that this is indeed the case. For example, the DiMascio *et al.* (1979) study (which compared the differential effects of IPT, a tricyclic, and a combination of both on 81 acutely depressed subjects over sixteen weeks[487] found that, far from being exclusive forms of active treatment, the effects of psychotherapy and pharmacotherapy can actually be quite complementary, as DiMascio *et al.* (1979, p. 1454) explain:

> No consistent negative interactions between treatments were found. The effects of both treatments in combination were additive. Patients who received combination treatment had the most symptom reduction.
>
> The additive effect of combined treatment was largely due to the differential effect of the two treatments. Pharmacotherapy had its effect mainly on the vegetative symptoms, sleep disturbance, somatic complaints, and appetite...the effects of psychotherapy were mainly on depressed mood, suicidal ideation, work and interests.

Similarly, a recent study by Beck *et al.* found that the combination of cognitive therapy and pharmacotherapy (amitriptyline) did somewhat better than either treatment alone, but not by a wide margin: an 88 percent response rate for the combination, as compared to a 75% rate for each single modality.[488]

Thus, subjects who are disturbed by both the vegetative symptoms and the more cognitive ones may want to consult a psychiatrist who can provide both treatments. In either case, FOLK PSYCHOLOGY IS HERE TO STAY, especially in psychiatric medicine, where some form of psychotherapy either has to be used as the primary form of treatment when somatic treatments aren't indicated, or as an adjunctive means, in order to get patients to comply with the medical program or to get enhanced benefits. And this is true in general medicine, as well, not only with respect to compliance, but also with respect to cutting costs and increasing health benefits for people with psychosomatic ailments, as I mentioned in Chapter Six.[489]

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counseling, and the awareness of emotional factors in health that were part and parcel of the ideal physician's way of practicing – while not labeled psychotherapy – were always an essential component of the physician's behavior." Similarly, Marshall Edelson argues that "Language as a medium of influence is as important a part of the clinician's armamentarium as the drug or scalpel," in "Language and Medicine" (in *Applied Psycholinguistics and Mental Health*, R.W. Rieber, ed. New York, Plenum Press, 1980, p. 178). Among the reasons Edelson gives are the facts that physicians use language to i) elicit information from patients in order to make a diagnosis; ii) discover the patients' attitudes about their condition in order to inform their course of treatment; and iii) influence the patients' conditions by informing them about their condition, soliciting their informed consent, and activating the placebo effect.

[487] See also Weissman *et al.*, "The Efficacy of Drugs and Psychotherapy in the Treatment of Acute Depressive Episodes," *American Journal of Psychiatry* 136, 1979, 555-58.

[488] See A.T. Beck, S.D. Hollon, J. Young, R.C. Bedrosian, and D. Budenz, "Combined Cognitive-Pharmacotherapy versus Cognitive Therapy in the Treatment of Depressed Outpatients" (*Archives of General Psychiatry* 42, 1985, 142-48), reported in Hollon and Beck (1986, p. 452).

[489] E.g., in reviewing studies of the effects of psychotherapy on asthmatic patients in their "Mental Health Services and Medical Utilization," Herbert Schlesinger, Emily Mumford, and Gene Glass found that the psychotherapy groups used less medicine, made fewer emergency room visits, required less subsequent hospitalization, and reported less anxiety and difficulty in breathing than did the control group, and they report, "[...only 23% of those subjects who received psychotherapy used as many medical services subsequently as 50% of the control subjects who did not receive

The Long-Term Limitations of Pharmacotherapy

As I've indicated in the text, ultimately I'm arguing that we should keep ***both*** intentional psychology and neuropsychology in full force and that it would be a serious mistake to try to eliminate either one, given not only their independent merits, but also the fact that they should frequently be used in tandem. However, although I'm no abolitionist, in what follows, I shall explain why psychotherapy is often preferable to pharmacotherapy, even in the most serious cases, because of the latter's long-term limitations.

Let's start with the vast majority of cases of depression, which fall in the more "moderate" end of the spectrum. From the medical point of view, Cognitive and/or Interpersonal psychotherapies are indicated for these cases *rather than* pharmacotherapy, at least initially (unless the patient is mute or simply can't abide talking to anybody about their troubles, e.g.), because as we've seen from the NIMH study, they're equally effective in combating depression as the paradigmatic antidepressant imipramine, but they achieve their results without inducing the latter's debilitating and dangerous physical side-effects. Talk therapy has adverse effects of its own, of course, as we saw, such as fostering the dependency, impoverishment, or even misery and rejection and humiliation of patients, but they're not inherent to the treatment, and they can be guarded against through the processes of licensing and selecting therapists, and most importantly, they're not lethal. Thus, since psychiatry falls under the aegis of medicine, which is bound by the Hippocratic Oath not to harm patients, then barring absolutely prohibitive expense, its practitioners should at least *attempt* to use intentional treatments on their depressed or neurotic patients first, or else refer them to someone who will, to see if they can achieve beneficial results without imposing risks. And given that cognitive therapy is a short-term form of therapy, which can be conducted by social workers and volunteer "paraprofessional" psychologists, if need be, and lasts only 10-12 weeks (or about 16 sessions), economic costs aren't a determining factor here – especially considering that the "complications" of excessive and irrational drug therapies can result in increased hospital admissions and stays, and incur considerable expenses in the long run.[490]

But what about the cases at the ***most*** serious end of the depression spectrum, where the effectiveness of psychotherapy proved to be quite limited, while imipramine did a little bit better – aren't antidepressants definitely indicated here, instead? Surprisingly, perhaps, the answer is "No," because antidepressants are actually superfluous and even contraindicated in such cases, for several reasons: 1) although they do slightly better than psychotherapy in elevating seriously depressed peoples' moods, they don't do all that well; 2) many of them are sufficiently potent that they are frequently used as the actual instrument of suicide; and 3) according to neuropsychiatry's own doctrine, ECT is indicated in such cases. Let's start with the first point.

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psychotherapy. It is worth noting, too, that in more than half the experimental versus control group studies, the control groups received medical treatment that was not given to the psychotherapy groups." (in VandenBos 1980, p. 94)

[490] Neuropsychology thus seems to lead to this cruel disjunction: either the therapeutic rationale justifying its psychoactive drugs is *wrong*, and its patients are being subjected to a variety of iatrogenic conditions including death for no good medical reason; or it's *right*, and these sorts of adverse reactions are probably the *inevitable* results of interfering with our brains' complex biochemistry and homeostatic mechanisms.

As we heard, Churchland (1988) pits the "qualified" success of neuropsychology's prototypical drugs against folk psychology's allegedly more limited approach, but after hearing so much about the side-effects which so qualify their success, the time has now come to ask once again, "Just how well ***do*** they control depression, anyway?"

But now let's turn things around a bit and see why they're bad even in the short run especially in the most serious cases; that is, let's consider the problem of antidepressants and suicide, which is quite a serious one.

Depression and Suicide

As I've mentioned, to my knowledge, psychotherapy is almost never lethal, although it has potential abuses of its own. In contrast, as we've seen, there are a number of ways that anti-depressants can and do kill us, either in-directly (e.g., through accidents involving vehicles or other machinery being operated by people taking drugs which cause drowsiness, blurry vision, impaired co-ordination, and other symptoms that affect their concentration and performance), or *directly*, mainly by causing cardiac arrests or respiratory failure, either through accident – or design.

The "grim irony," as Peter Breggin terms it, confronting neuropsychology is that the very drugs that are being administered to "cure" depressed and suicidal patients are frequently being used as the actual instrument of their destruction, instead.[491] As Breggin explains in the note, antidepressants are not only positively ineffective when it comes to treating seriously depressed and suicidal subjects, but they're also downright dangerous, considering that their side-effects and delayed onset of action can contribute to the suicidal mood, instead of alleviating it, and they can easily be taken in lethal doses – as little as one week's supply can produce a fatal overdose.[492] In some cases, suicidal patients overdose on their drugs not only because they're suitable to the task (given their convenience and potency), but also because they want to "get back" at what they perceive as the insensitivity of the doctor treating him or her, as Karon and VandenBos (1981, p. 276) point out. Knowing that these medications are often used for these purposes, doctors should

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[491] On the problem of suicide by antidepressants, see Breggin (1983, pp. 179-80), which is reproduced in the next note; Swonger and Constantine (1983, pp. 151-52); or Schoonover (1983, pp. 50-51).

[492] Concerning the problem of administering antidepressants to suicidal subjects, Breggin (1983, pp. 179-80) writes,

> "It is agreed by almost all the authorities that there is no evidence that the antidepressants ameliorated suicidal tendencies. Instead there are frequent warnings in the literature and pharmaceutical company advertising that the antidepressants cannot be relied on for suicidal patients, in part because of the lengthy period required before their action becomes apparent, and in part because of their questionable efficacy. Thus these allegedly specific drugs for depression are specifically *not* useful in treating the most serious and objectively measurable manifestation of depression, suicide risk.
>
> There is indeed a grim irony in using these drugs for depressed patients: as little as one week's (or less) supply of the pills can be used to produce a serious if not fatal overdose....In 1979 the most commonly prescribed antidepressant, Elavil [a tricyclic], ranked near the top as a cause of drug-related death....A more recent report...indicates that the major anti-depressants are overtaking the barbiturates as the medications most frequently involved in serious overdose.
>
> ...consider the situation of the depressed person who is treated with major antidepressants. The patient is told that the drugs will make her feel better. She begins to take them, and discovers that she is feeling worse and worse. She cannot distinguish in her own mind between the general neurotoxicity produced by the agents and her own personal mental upset. Indeed, she hasn't been told that the drugs have any effect but to make her feel better. Yet she feels worse *despite* the treatment. It is easy to see how such a condition might encourage more despair, and suicide."

stop prescribing them if some alternative means of therapy is available, because supplying suicidal subjects with "lethal potions" violates at least two clauses in the Hippocratic Oath.[493]

Intentional psychology, on the other hand, has far more positive uses when it comes to seriously suicidal subjects. In fact, sometimes it is of vital service, indeed, as the essential first step to recovery, as when intelligent and sensitive discourse is used to help talk "jumpers" off ledges or bridges, for example, and persuade them to come in for treatment. But clearly psychotherapy can't always go it alone in the most severe cases. When patients have become so "out of contact with reality and so totally disabled by mental illness that they are incontinent and unable to feed or otherwise care for themselves," as Small *et al.* (1986, p. 343) put it, electroconvulsive therapy is indicated, too.[494] In such cases, ECT can literally be a life-saver, because it can at least temporarily restore the patients to a semblance of normalcy (since they literally forget their troubles), and it takes effect immediately, whereas the onset of action of most anti-depressants takes several weeks, and psychotherapy even longer. However, ECT can be dangerous,[495] and the side-effects such as memory loss[496] and difficulties in speaking[497] increase with each episode, so it must be used sparingly, and it should be followed up with intensive psychotherapy, because it has next to no prophylactic value of its own.[498]

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[493] I.e., the two provisions of the Hippocratic Oath to "Above all, do no harm," and to "neither give a deadly drug to anybody if asked for it, nor...make a suggestion to this effect." A related reason for eliminating these potent drugs (rather than talk therapy) is that they're just plain dangerous to have around the house, even apart from the risks to the depressed or suicidal patients themselves. For example, as Ray (1983, pp. 284) reports, "A 1980 alert to physicians by the FDA pointed out how dangerous the tricyclics can be when accidentally taken by children: 1000 emergency room vists a year, resulting in 500 hospitalizations and 10 deaths."

[494] See Weiner (1985, p. 1563); or Bassuk *et al.* (1983, p. 32) or even Glasser (1984) on ECT's indicated uses in treating acutely depressed people.

[495] E.g., Wiener (1985, p. 1562) notes, "The mortality rate with ECT has been variously estimated between 1:1,000 and 1:10,000 patients; roughly the same rate associated with brief general anesthesia itself. Death is usually on the basis of cardiovascular complications and is more likely to occur in patients whose cardiac status is already compromised."

[496] Both kinds of memory loss are involved with ECT: retrograde and antrograde amnesia (indicating memory of events prior to and subsequent to the treatment, respectively); many of the losses are permanent, and these lost parts of people's lives might be of considerable significance, such as being able to recognize and converse with a former neighbour or colleague, or even find your way home. See, e.g. Breggin (1981, pp. 254-57, 260) on losses such as forgetting one's filing system, or how to ride the subway home, or who former friends or acquaintances are.

[497] ECT's adverse effects are similar to and potentially more destructive than blows to the head: they can cause coma, memory loss, and impaired speech like Mohammed Ali's (although reportedly Ali's slurred speech is due to Parkinson's disease); see, e.g., Friedberg (1977, p. 1011), or Rosenhan and Seligman (1984) p. 326.

[498] The (1978) APA Task Force on ECT as well as even some of its staunchest advocates such as Small report that ECT has little prophylactic value in depression: it is only really effective for one course of six to nine treatments and ***it doesn't prevent relapse***. First, as the APA (1978, p. 19) itself notes,

> "In better studies where more severely depressed patients were treated, the average number tended to be between six and nine. Likewise, there is no evidence that extending a course of therapy will yield better clinical results or prevent relapse. In fact, a recent well-controlled study by Barton *et al.* [JL Barton, S Mehta, RP Snaith, "The prophylactic value of extra ECT in depressive illness," *Act Psychiat Scand* 49(4), 1973, 386-392] demonstrated no increased efficacy or prophylactic value in extended courses of ECT. These researchers assigned one group of patients with primary depressive illness to a course of ECT sufficient to elicit recovery and another group to two extra treatments after recovery. No difference in outcome between the two groups was demonstrated over a three month follow-up period."

Similarly, Wiener (1985, p. 1562) notes, "It can be categorically stated that an acute course of ECT induces a remission but does not, in itself, prevent relapse. A strong consideration of post-ECT maintenance treatment should always be made"; and even Small *et al.* (1986, pp. 354-55) concede, "ECT can provide a rapid, effective means of control of symptoms but the ultimate outcome of illness depends more upon continued medical supervision and psychotherapeutic interventions."

Thus, even in the most severe cases of depression, psychotherapy (sometimes supplemented by ECT) has advantages over pharmacotherapy, despite the latter's more immediate effects in improving the vegetative symptoms. Now I can give my closing arguments.

Conclusion: Closing Arguments in Defense of Intentional Psychology

Judging partly by the "qualified success" of neuropsychiatry's treatments of "the major forms of mental illness," neuroeliminativists submit that neuroscience may some day be able to phase out the methods and theories of intentional psychology altogether, by developing the means to not only determine how people's brains are 'wired', but also to rewire them or correct their malfunctions, without needing to bother its practitioners with reasoning with their patients or interpreting the content of their beliefs, feelings, or experiences. Of course, I can't rule out this possibility that some day we could safely rely upon exclusively neuropsychiatric treatments for our problems, but for the time being, at least, it seems to be little more than "a gleam in Churchland's eye" (as Putnam [1988, p. 110] puts it), for a number of reasons. To begin with, virtually all the psychiatric medications that we know about *do* induce side-effects, and they don't work that well, anyway, especially in the long run. And the situation is likely to stay that way if the medical model is at all right about the fundamentally neurochemical nature of mental illnesses, since neurotransmitters *are* so fundamental to our functioning and anything affecting their balance tends to harm many systems at once.[499] To cap it off, pharmacotherapy frequently needs to be accompanied by psychotherapy, anyway, if only to ensure that patients comply with their treatments, and quite possibly to get enhanced synergistic effects. Moreover, many psychological problems seem to be induced not by physical abnormalities in subjects *per se*, but by traumatizing and devastating life experiences which adversely affect their self-images and their outlooks on life.

Furthermore, in light of the fact that we should keep treatments with good safety records available for medical purposes, plus the fact neuropsychiatric interventions do have such significant hazards, I submit on behalf of intentional psychology and troubled people everywhere that the burden of proof is definitely on the eliminativists to show that intentional psychology is (almost) *never* useful if they want to hasten its demise or call for a reduction in its already too constricted funding. And finally, I submit that they can't make good on that charge even if they tried, because contrary to Churchland's (1988, p. 46) complaint that folk psychology cannot "cure" mental illnesses and finds them "almost completely mysterious," a closer look at the clinical domain shows that applied intentional psychology is at least as useful as its rival is in understanding and treating depression, and its services continue to be needed in both psychiatry and in general medicine.

In sum, then, my pragmatic argument in intentional psychology's defense is that by all indications, we won't and shouldn't phase out intentional psychology, since even in the domain of the

[499] Neuropsychology thus seems to lead to this cruel disjunction: either the therapeutic rationale justifying its psychoactive drugs is *wrong*, and its patients are being subjected to a variety of iatrogenic conditions including death for no good medical reason; or it's *right*, and these sorts of adverse reactions are probably the *inevitable* results of interfering with our brains' complex biochemistry and homeostatic mechanisms.

"best" cases for neuropsychology, it turns out that folk psychology is needed as either the primary or adjunctive means of treatment, so it isn't about to be superseded by neurobiology anytime in the foreseeable future. In fact, as we saw at the end of Chapter Six, despite the widespread medicalization of life in the West, the field of clinical psychology as a whole is growing, not shrinking, not only because Ph.D.'s work cheaper per hour than M.D.'s do,[500] but also because mental health consumers are justifiably starting to become wary of the sorts of iatrogenic effects we've heard about. Thus, given everything we know, eliminative materialism, considered as both a prediction and a recommendation that folk psychology could be phased out in the wake of scientific progress, is very likely *wrong*, because intentional approaches provide us with certain desperately needed and indispensable services, whereas the medications dispensed by neuropsychology are all too apt to cause serious harm, in violation of the injunction regulating the applied disciplines at issue. If we know what's good for us, then, we won't eliminate intentional psychology or purge it from the ranks of the academy or applied science in favor of purely neuropsychological approaches, we'll press it into increased service, instead.

However, lest there be any misunderstanding about the extremity of *my* position, I should emphasize that I am by no means an eliminative intentionalist, since I fully acknowledge the need for qualified medical doctors, neuroscientists, and even neurosurgeons to help deal with the physiological problems that many psychiatric patients do have, such as hyperthyroidism or brain tumors. My only concern here is that intentional psychology get its due, as well, for its services are desperately needed by millions in our society alone.

[500] See the final note in Chapter Six, or Yates and Newman, in VandenBos (1980, esp. pp. 203-205) on some of the financial reasons why psychiatrists are shrinking in number relative to clinical psychologists.

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